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ABSTRACT

With the passage of welfare reform, the consolidation of child care programs, the attainment of more state options under Medicaid, and the enactment of the State Children's Health Insurance Program, states are now able to significantly change fundamental health and social policies related to children. This project of the Southern Institute on Children and Families, funded by the Robert Wood Johnson Foundation, was designed to help southern states identify ways to improve access to benefits by low-income working families with children. Specific activities of the project included: the development of outreach information brochures and videotapes for use in southern states; site visits in 17 southern states and the District of Columbia to identify policies and procedures that present access barriers for low-income families and identify strategies being used to improve access to benefits; and a conference to promote dialogue on interagency and interdepartmental issues affecting low income families. This report outlines actions states are taking and can take to improve access to benefits, including issues related to the affordability of health coverage and child care in relation to family income, the categorical structure of benefit programs, counterproductive eligibility rules, inadequate transportation services, and the need for aggressive outreach. State strategies are summarized and state-by-state data are presented where available. Presentations from the Southern Regional Forum on Improving Access to Benefits for Families with Children are summarized. Six appendices include sample outreach brochures, state data on Aid to Families with Dependent Children application denials, and state contacts in fourteen states for Head Start collaboration. (KB)

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THE SOUTHERN INSTITUTE on Children and Families

SOUTHERN REGIONAL INITIATIVE To Improve Access To Benefits For Low Income Families With Children

February 1998

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SOUTHERN REGIONAL INITIATIVE TO IMPROVE ACCESS TO BENEFITS FOR LOW INCOME FAMILIES WITH CHILDREN

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The Southern Institute on Children and Families is an independent nonprofit public policy organization. It endeavors to improve opportunities for children and families in the South with a focus on disadvantaged children. Through special projects and surveys, the Southern Institute on Children and Families spotlights health, social, education and economic issues of regional significance. It works to encourage public/private sector collaboration on behalf of children and families and seeks to remove bureaucratic and other barriers that restrict access to needed services. The Southern Institute on Children and Families is funded through grants and contributions.

The views expressed in this report are those of the authors and no official endorsement by The Robert Wood Johnson Foundation is intended or should be inferred.

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EXECUTIVE SUMMARY

With the passage of welfare reform, the consolidation of child care programs, the attainment of more state options under Medicaid and the enactment of the State Children's Health Insurance Program (CHIP), states are now in the position to make significant changes in fundamental health and social policies related to children. As states move forward to design and implement public policies that support low income working families, it is critical that the perspective of families be included in their deliberations.

In studies conducted by the Southern Institute on Children and Families, a resounding message from families has been that they need assistance in paying for child health coverage, child care and other needs and they would like such assistance to be related to their income. They are frustrated by public programs that provide benefits based on arbitrary time limits and other rules that are not related to their ability to pay.

An economic reality check demonstrates the income versus expenses predicament faced by low wage families. Table 1 displays the annual income for a family of three earning at the minimum wage (80% of the federal poverty level), 100%, 150% and 200% of the federal poverty level.

TABLE 1
VARIOUS LEVELS OF ANNUAL INCOME RELATED TO THE 1997 FEDERAL POVERTY LEVEL FOR A FAMILY SIZE OF THREE

80% of Poverty (Full Time Minimum Wage)	100% of Poverty	150% of Poverty	200% of Poverty
$10, 712	$13,330	$19,995	$26,660

Source: Southern Institute on Children and Families, 1997.

Given these income levels, it is not difficult to understand how families earning these amounts are in a constant economic struggle to pay for housing, utilities, food, clothing, transportation, health care, child care and other basic

needs. And, it's not difficult to understand why they become discouraged when they encounter public policies and programs that fail to recognize simple economic realities.

In addition to implementing new strategies to assist low income families, states must move aggressively to utilize existing opportunities to bolster families who work in low wage jobs. The extent to which states take advantage of and promote available programs varies widely across the southern region.

Southern Regional Initiative to Improve Access to Benefits for Low Income Families With Children

In February 1997, the Southern Institute on Children and Families received support from The Robert Wood Johnson Foundation to launch a regional outreach initiative to help southern states identify ways to improve access to benefits for low income working families with children. Specific objectives of the project are:

- To identify specific actions needed to improve access to child health coverage and child care assistance;
- To assist and encourage states to implement aggressive outreach strategies, especially in the development of more effective communication with families about the availability of health coverage, child care and other benefits; and
- To make the eligibility process for child health coverage more accessible, dignified and user friendly.

Development of Information Outreach Materials

Public policy makers often assume that the passage of laws and/or the appropriation of funding will result in benefits reaching the citizens who are eligible to receive them. With programs for low income families, however, insufficient attention and resources have been devoted to the development of effective communication strategies to inform them about available benefits. Studies by the Southern Institute have shown that many families are not aware of government benefits that can help provide health coverage for their children, assist them in paying for child care, and allow them to keep more of what they earn.

This project builds on Southern Institute initiatives undertaken in cooperation with health and human service officials in **NORTH CAROLINA** and **GEORGIA** to develop effective information outreach materials. Through the use of 27 focus groups conducted in nine urban and rural counties with welfare and transitional benefits recipients, community organizations and employers, the Southern Institute developed easy to understand information outreach brochures to convey positive messages about the following benefits for low income working families:

- Medicaid benefits for children during and after the welfare related transition period;
- Medicaid benefits for children in low income working families who have no current or recent connection to the welfare system;
- Earned Income Tax Credit (EITC) benefits, especially the monthly advance which is available at no cost to the employer;
- Child care assistance for families leaving welfare for work and child care assistance for low income working families in general;
- Food stamps; and
- Child support enforcement.

The project provides technical assistance to states to replicate the information outreach brochures developed in Georgia and North Carolina and also produced videos to be used in conjunction with the dissemination of the information outreach brochures. All states and the District of Columbia have indicated that they will take advantage of the opportunity to produce the brochures for use in their outreach efforts.

At present, 10 southern states have completed production and are using the brochures statewide. The project also produced videos based on the brochures. (See Table 6 for state by state information.)

State Site Visits

From March through September 1997, the project sponsored site visits to the following 17 southern states and the District of Columbia:

Alabama	Louisiana	South Carolina
Arkansas	Maryland	Tennessee
Delaware	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

The Foundation for Child Development provided support with two of the state site visits.

The site visits were conducted in cooperation with governors' offices and state health and human service officials. A total of 445 persons participated in the site visit meetings. The site visit meetings identified policies and procedures that present access barriers for low income families and also identified strategies states are using to improve access to benefits, primarily child health coverage and child care subsidies.

On completion of the 18 site visits, the project sponsored the Southern Regional Forum on Improving Access to Benefits for Families With Children to promote dialogue on interagency and interdepartmental issues affecting low income families. The forum brought together state policy staff who work with health coverage, child care, eligibility and transportation issues. Persons attending the regional forum were designated by each of the 17 governors, as well as designees from the District of Columbia. Forum presentations are summarized in the relevant chapters of this report and contacts for further information are provided.

Actions That Can Improve Access to Benefits

This report outlines actions states are taking and actions that can be taken to improve access to benefits for low income families with children. The chapters include discussion of access issues related to the affordability of health coverage and child care in relation to family income, the categorical structure of

benefit programs for low income families with children, the complex and often counterproductive eligibility rules, inadequate transportation services and the need for aggressive state and community outreach. Additionally, state strategies to address needs are summarized and state-by-state data is presented where available. The recommended actions are presented below and appear at the end of the relevant chapters.

Child Health Coverage

1) To increase the number of low income children who have health coverage, states should utilize the opportunities presented by the Medicaid program, CHIP and state/local coverage programs to design a coordinated approach to child health coverage.

   - To assure health coverage for all children living in poverty, states should accelerate the federal Medicaid phase-in for all children 18 years old and younger.

   - To prevent inequity of health coverage across age groups, states should design coverage programs for low income children to achieve uniformity in age groups and income levels.

2) To allow states to efficiently provide Medicaid coverage for children and families who are eligible under the state welfare (TANF) program, the Medicaid law can be amended to give states the option to create a Medicaid eligibility category which mirrors TANF eligibility.

3) To assure that families applying for welfare (TANF) understand that they do not have to be on welfare to obtain Medicaid coverage for their children, states should fully inform and link applicant families to health coverage opportunities, such as Medicaid poverty related children coverage, Section 1931 coverage, state CHIP coverage and other state/local coverage programs.

4) To avoid denying Medicaid coverage to children in income eligible families who have resources that exceed state asset limits, states should exempt assets when determining eligibility for child health coverage.

5) In order to reduce the chances that reporting requirements could result in income eligible families losing Medicaid benefits during the first year after leaving welfare, the federal Medicaid law can be amended to give states the option to eliminate reporting requirements in the second six months of Transitional Medicaid.

6) To avoid requiring families to spend a specified time on welfare in order to obtain health coverage, the federal Medicaid law can be amended to give states the option to eliminate the rule that requires families to receive cash assistance for three out of the previous six months in order to be eligible for Transitional Medicaid.

7) To assist low income families to access health coverage for their children, states and communities should design and implement aggressive outreach strategies.

8) To improve access to child health coverage, states and communities should identify and implement actions needed to make the application process less burdensome for families.

9) In order to avoid erroneous or premature termination of Medicaid benefits for a child, states should develop and implement information systems which assure that children are automatically transferred from one eligibility category to another without disruption to their Medicaid benefits.

10) To assure that the eligibility system is regularly examined with the goal of reducing policy and procedural barriers, states and communities should establish a periodic review process of eligibility outcome data.

Child Care Assistance

1) To assist more low income families with the high cost of child care and to discourage welfare as an entry point for child care assistance, states should identify and implement actions to achieve an income based system of child care subsidies for low income working families with no requirement that a family be on welfare for any period of time in order to obtain assistance in paying for child care.

2) To avoid denying child care assistance to children in income eligible families who have resources that exceed state asset limits, states should exempt assets when determining eligibility for child care assistance.

3) To assure that the application and recertification process is not burdensome for low income families seeking child care assistance, states should review eligibility policies and procedures, including recertification periods and verification requirements.

4) In order to provide continuity of child care assistance, states should review policies regarding agency initiative in making category changes for low income families whose children remain eligible.

5) To assure that families know about available child care assistance, states and communities should design and implement outreach strategies to communicate the availability of child care assistance for low income working families.

6) To foster cooperation with Head Start, states should identify and disseminate information on successful Head Start collaboration strategies and document issues that need to be addressed at the federal level.

Transportation

1) To develop more efficient and responsive transportation solutions for poor and low income citizens, states should create state level or multi-state work groups composed of the various public and private agencies that purchase or provide transportation services. The objectives would be to:

   - Identify strategies to effectively and efficiently coordinate transportation services designed to assist low income citizens; and

   - To identify strategies to help low income families acquire personal automobiles.

   Including advocacy groups and/or family representatives in the deliberations will provide needed input from user groups. The experience of local initiatives should be examined and information on state or federal demonstration projects should be reviewed. Federal technical assistance should be provided to avoid misinterpretation of federal policies and rules and to identify coordination and collaboration opportunities.

2) To avoid penalizing low income families who own an automobile, states should eliminate automobile asset testing for families applying for child health coverage, child care assistance and other benefits.

Earned Income Tax Credit

1) To assure that families learn about the EITC, states should conduct information outreach campaigns, with special efforts targeted to families on welfare, and provide EITC information and forms to eligibility workers.

2) To assure that children do not lose Medicaid because their family claimed the EITC and did not spend their refund quickly, states should exclude the cash received through the EITC, whether through the advance method or end of year tax refund, from the state definition of assets.

3) To avoid children losing Medicaid coverage, the federal government can enact the same policy it has for income and thus disallow the counting of EITC cash as an asset in determining Medicaid eligibility.

CHAPTER 1
INTRODUCTION

With the passage of welfare reform, the consolidation of child care programs, the attainment of more state options under Medicaid and the enactment of the State Children's Health Insurance Program (CHIP), states are now in the position to make significant changes in fundamental health and social policies related to children. While producing much controversy, welfare reform brought long overdue attention to the economic issues and incentives intertwined in welfare and health policy. Since its passage, states have made greater investments in benefits to help low wage families with high cost items like health coverage and child care.

As states move forward to design and implement public policies that support low income working families, it is critical that the perspective of families be included in their deliberations. Studies by the Southern Institute on Children and Families (hereinafter referred to as the Southern Institute) often involve personal interviews and focus groups with families where they are asked to share their views and are encouraged to make suggestions on what actions are needed to improve policies and operations. In Southern Institute studies on health and welfare issues, a resounding message from families has been that they need assistance in paying for child health coverage, child care and other needs and they would like such assistance to be related to their income. They are frustrated by public programs that provide benefits based on arbitrary time limits and other rules that are not related to their ability to pay.

An economic reality check demonstrates the income versus expenses predicament faced by low wage families. Table 1 displays the annual income for a family of three earning at the minimum wage (80% of the federal poverty level), 100%, 150% and 200% of the federal poverty level.

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In addition to implementing new strategies to assist low income families, states must move aggressively to utilize existing opportunities to bolster families who work in low wage jobs. The extent to which states take advantage of and promote available programs varies widely across the southern region.

Southern Regional Initiative to Improve Access to Benefits for Low Income Families With Children

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- To assist and encourage states to implement aggressive outreach strategies, especially in the development of more effective communication with families about the availability of health coverage, child care and other benefits; and
- To make the eligibility process for child health coverage more accessible, dignified and user friendly.

Development of Information Outreach Materials

The project builds on Southern Institute initiatives undertaken in cooperation with health and human service officials in **GEORGIA** and **NORTH CAROLINA**. Through the use of 27 focus groups in nine urban and rural counties with welfare and transitional benefits recipients, community organizations and employers, the Southern Institute developed and tested eye-catching, easy to understand information outreach brochures to convey positive messages about the following benefits for low income working families:

- Medicaid benefits for children during and after the welfare related transition period;
- Medicaid benefits for children in low income working families who have no current or recent connection to the welfare system;
- Earned Income Tax Credit (EITC) benefits, especially the monthly advance which is available at no cost to the employer;
- Child care assistance for families leaving welfare for work and child care assistance for low income working families in general;
- Food stamps; and
- Child support enforcement.

The project provides technical assistance to states to replicate the information outreach brochures initially developed in Georgia and North Carolina.

The project also produced videos to be used in conjunction with the dissemination of the information outreach brochures. Two videos were produced to inform families about available benefits and one video provides information for employers. The videos for viewing by families and community organizations were also produced in Spanish.

State Site Visits

From March through September 1997, the project sponsored site visits to the following 17 southern states and the District of Columbia:

Alabama	Louisiana	South Carolina
Arkansas	Maryland	Tennessee
Delaware	Mississippi	Texas
Florida	Missouri	Virginia
Georgia	North Carolina	West Virginia
Kentucky	Oklahoma	

The Foundation for Child Development provided support to assist with two of the state site visits.

The site visits were conducted in cooperation with governors' offices and state health and human service officials. A total of 445 persons participated in the site visit meetings. The site visit discussions identified policies and procedures that present access barriers for low income families and also identified strategies states are using to improve access to benefits, primarily child health coverage and child care subsidies. The discussions were centered on four areas:

- Outreach strategies to both inform families about available health coverage, child care and other benefits and to assist them in enrollment;
- Eligibility policies related to Medicaid coverage for poverty related children and welfare families;
- Simplification of Medicaid eligibility procedures and requirements; and
- Eligibility policies and procedures related to child care assistance;

Appendix A provides information on state contacts who were responsible for handling arrangements for the site visits.

Southern Regional Forum

On completion of the 18 site visits, the project sponsored the Southern Regional Forum on Improving Access to Benefits for Families With Children. The forum brought together state policy staff who work with health coverage, child care, eligibility and transportation issues. Persons attending the regional

forum were designated by each of the 17 governors, as well as designees from the District of Columbia. Other guests attending the forum included representatives of the National Governors' Association, Administration on Children and Families, Health Care Financing Administration, advocacy groups, national policy researchers and foundation representatives

The regional forum was designed to share information gained on the state site visits and to promote dialogue on interagency and interdepartmental issues affecting low income families. The opportunity to learn about issues and strategies used in other states and in other program areas was well received by the attendees. A total of 120 individuals were in attendance. Five panels of state, federal and private sector representatives provided information on the following topics:

- Supporting work through child care subsidies;
- Making health coverage available to working families;
- Implementing state and community outreach;
- Removing health coverage eligibility barriers; and
- Reaching for transportation solutions

The forum presentations are summarized in the relevant chapters of this report and contacts for further information are provided. See Appendix B for the forum program.

Summary of Report

This report outlines actions states are taking and actions that can be taken to better support low income working families with children. Most of the information contained in the report was gathered on state site visits conducted during the project. Some additional surveying was required to collect updated information on issues discussed in the report. A brief review of the chapters is presented below.

Chapter 2 discusses the information outreach brochures and videos developed by the Southern Institute and provides the status of efforts to replicate the information outreach brochures throughout the southern region.

Chapter 3 discusses issues and strategies states can consider in providing health coverage for more low income children. The chapter also discusses federal policies that restrict access to Medicaid coverage, as identified on the state visits. The chapter outlines Medicaid issues related to families leaving welfare for work and low income families who have no connection to the welfare system. Information is also presented on state Medicaid eligibility levels for children as of September 1, 1997 and state Medicaid plan amendments submitted by southern states as part of the State Child Health Insurance Program (CHIP). And finally, the chapter contains a discussion of eligibility outreach and eligibility simplification issues.

Chapter 4 discusses issues, provides survey results and presents information on strategies states can consider when designing actions to improve access to child care assistance.

Chapter 5 discusses transportation issues and strategies.

Chapter 6 provides information and discusses issues related to the Earned Income Tax Credit (EITC).

Chapter 7 provides information on recent federal developments relevant to the project.

CHAPTER 2
INFORMATION OUTREACH

Most communication on benefits and services for families has been in the form of bureaucratically worded documents that advise of rights and responsibilities in connection with receipt of benefits. Rarely are there materials that communicate information on available benefits in an easy to understand, "user friendly" manner.

Public policy makers often assume that the passage of laws and/or the appropriation of funding will result in benefits reaching the citizens who are eligible to receive them. With programs for low income families, however, insufficient attention and resources have been devoted to the development of effective communication strategies to inform them about available benefits. Thus, many families are not aware of government benefits that can help provide health coverage for their children, assist them in paying for child care, and allow them to keep more of what they earn.

Initial Development of Information Outreach Brochures

In a study conducted by the Southern Institute in cooperation with the North Carolina Department of Human Resources and the Tennessee Department of Human Services, serious misconceptions about the availability of benefits were identified.[1] The findings showed that families on welfare and families receiving Transitional Medicaid, as well as community organizations who work to help them, lacked information or were misinformed about the availability of health coverage and other benefits.

As part of the study, personal interviews were conducted with randomly chosen recipients of Aid to Families With Dependent Children (AFDC) and Transitional Medicaid benefits. During the interviews, specific questions were

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[1] Sarah C. Shuptrine, Vicki C. Grant and Genny G. McKenzie, A Study of the Relationship of Health Coverage to Welfare Dependency (Columbia, SC: Southern Institute on Children and Families, March 1994).

asked in order to determine the degree to which recipients understood how benefits changed when they left welfare for work. The questions related to AFDC (the cash assistance welfare program), Medicaid, food stamps, child care and housing.

Table 2 shows the findings from the recipient interviews. The program least understood was Medicaid, with 76% incorrect responses. Forty-seven percent (47%) of the responses related to child care assistance were incorrect. Responses indicated that many believed that families had to be on welfare to receive any assistance with health coverage and child care.

TABLE 2
PERCENTAGE OF RECIPIENTS PROVIDING INCORRECT RESPONSES TO THE IMPACT OF EARNINGS ON BENEFITS

Benefit	Percentage Providing Incorrect Responses
AFDC	24%
Food Stamps	6%
Medicaid	76%
Child Care	47%
Housing	24%

Source: Southern Institute on Children and Families, 1994. Data collected from recipient interviews in Charlotte, North Carolina and Nashville, Tennessee.

The Southern Institute published its report in March 1994 and recommended that state social services officials in the southern states develop "user friendly" materials to effectively communicate the benefits available through various programs. With support from the North Carolina Department of Human Resources, 18 focus groups were held in six counties to assist in the development and testing of information outreach brochures that communicated the availability of Medicaid benefits for children, the Earned Income Tax Credit (EITC), child care and food stamps. Subsequent to the **NORTH CAROLINA** information outreach project, nine additional focus groups were held in three

counties in **GEORGIA** with support provided by the Georgia Division of Family and Children Services.

In each state, focus groups were held in urban and rural counties with the following groups: 1) AFDC and Transitional Medicaid recipients (chosen randomly); 2) community organizations; and 3) employers. In North Carolina, 144 persons participated in the focus groups. In Georgia, 89 persons participated.

In both states, pretest and post test questions were administered to measure the knowledge of focus group participants regarding general Medicaid eligibility rules for children, Transitional Medicaid, the Earned Income Tax Credit and child care. The pretest results in both states clearly demonstrated the need for aggressive information outreach. The **GEORGIA** pretest results are summarized below.

Recipients

- **55%** did not understand that if parents get off welfare because of work, their children would be able to get Medicaid.
- **57%** did not understand that even if a child's parents live together, the child can get Medicaid.
- **59%** did not know about the availability of Transitional Medicaid Assistance for up to one year.
- **78%** did not understand that children under age six are eligible for Medicaid at higher income levels than older children.
- **53%** did not know that if parents get a job, they might qualify to get more take home pay from the EITC.
- **41%** did not know that a paycheck plus money from EITC is much greater than a welfare check.
- **82%** did not understand that the money a working parent gets from the EITC does not count against Medicaid, AFDC, food stamps, SSI or housing benefits.
- **39%** did not understand that if parents get off welfare because of work, they can get help with child care expenses for up to one year.

Community Organizations and Providers

- **31%** did not know about the availability of Transitional Medicaid coverage for up to one year.
- **92%** did not understand that children under age six are eligible for Medicaid at higher income levels than older children.
- **39%** did not know that a paycheck plus money from the EITC is much greater than a welfare check.
- **42%** did not understand that the EITC does not count against Medicaid, AFDC, food stamps, SSI or housing benefits.
- **16%** did not know about the availability of Transitional Child Care benefits for up to one year.

Employers

- **21%** did not know that children do not have to be on welfare to be eligible for Medicaid coverage.
- **43%** did not know about the availability of Transitional Medicaid coverage for up to one year.
- **78%** did not understand that children under age six are eligible for Medicaid at higher income levels than older children.
- **50%** did not understand that the EITC is available to low income working families regardless of whether or not they owe taxes.
- **86%** did not understand that they could add a portion of EITC to the employee's paycheck each pay period.
- **50%** did not know about the availability of Transitional Child Care benefits for up to one year.
- **50%** did not know that there are programs that supplement the wages of low income workers with children at no cost to the employer.

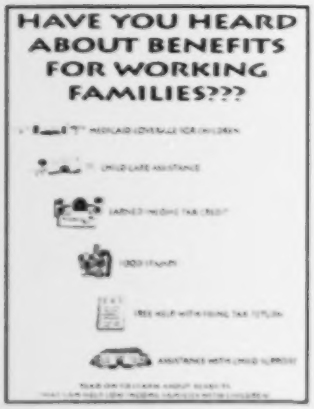
For illustration purposes, the first page of the three **GEORGIA** outreach brochures are displayed on page 12 and each brochure is included in its entirety in Appendix C.

After reading through the outreach brochure, focus group participants were given a post test to measure gains in knowledge. No discussion was held prior to the post test. Results showed that the communication effectiveness of the outreach brochures was statistically significant in both states. Table 3, Table 4 and Table 5 display the **GEORGIA** post test results by target group.

INFORMATION OUTREACH BROCHURES

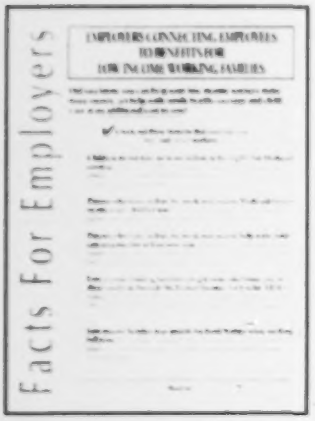
LEAVING WELFARE FOR WORK ISN'T AS SCARY AS IT SEEMS

This brochure is for use with families on cash assistance to help them understand that they do not have to be on welfare in order to receive benefits that can help them meet the needs of their children while working in low wage/no benefit jobs. It is ideal for review with welfare families at redetermination interviews and in job readiness classes. The brochure outlines benefits available to families during the transitional period, as well as benefits available beyond the transitional period. It provides information on Medicaid, the Earned Income Tax Credit, child care assistance and Food Stamps.



HAVE YOU HEARD ABOUT BENEFITS FOR WORKING FAMILIES???

This brochure is designed for general community outreach. It will help families who apply for cash assistance to understand that they can receive Medicaid and other benefits without having to be on welfare. It is also appropriate for distribution through schools, health providers, churches and other community organizations and to employers for dissemination in the workplace. The brochure provides information on Medicaid, the Earned Income Tax Credit, child care assistance, Food Stamps and Child Support Enforcement.



FACTS FOR EMPLOYERS

This brochure provides employers with information on how to link low income employees to benefits that basically supplement low wages at no cost to employers. The brochure is especially appropriate for employers who pay minimum wage or slightly above or employers who offer no or very limited benefits. It is an effective communication tool for use when making personal visits to employers and it is a valuable hand out at presentations to business groups. The brochure provides information on Medicaid, the Earned Income Tax Credit and child care assistance.

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TABLE 3
RECIPIENTS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM

Program	Pretest	Post Test
Earned Income Tax Credit	41%	86%
Medicaid	38%	81%
Child Care	76%	93%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

TABLE 4
COMMUNITY ORGANIZATIONS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM

Program	Pretest	Post Test
Earned Income Tax Credit	71%	96%
Medicaid	61%	98%
Child Care	81%	100%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

TABLE 5
EMPLOYERS
PERCENTAGE OF CORRECT ANSWERS
ON THE PRETEST and POST TEST, BY PROGRAM

Program	Pretest	Post Test
Earned Income Tax Credit	38%	100%
Medicaid	61%	96%
Child Care	50%	100%

Source: Southern Institute on Children and Families, 1996. Data collected for the Georgia Information Outreach to Reduce Welfare Dependency Project.

Replication of the Information Outreach Brochures in the Southern States

Following the development of the outreach brochures in Georgia and North Carolina, two states (**FLORIDA** and **TENNESSEE**) asked the Southern Institute to adapt the information outreach brochures for use by their states. Thus, when this project began, 13 states and the District of Columbia were not using the outreach brochures. On site visits to the remaining 13 southern states and the District of Columbia during this project, presentations on the information outreach brochures were made to those attending the state meetings.

States were informed that through this project the Southern Institute could provide technical assistance to adapt the information outreach brochures for use by their states. Printing and distribution costs would be the responsibility of each state.

The information outreach brochures were enthusiastically received by persons attending the site visit meetings. All states and the District of Columbia have indicated that they will take advantage of the opportunity to produce the brochures for use in their outreach efforts. At present, 10 southern states have completed production and are using the brochures statewide. Table 6 provides the status of replication of the information outreach brochures across the southern region.

TABLE 6 STATUS OF INFORMATION OUTREACH BROCHURES JANUARY 1998			
State	**In Use**	**In Draft Stage**	**Planning To Use**
Alabama			√
Arkansas			√
Delaware	√		
District of Columbia		√	
Florida	√		
Georgia	√		
Kentucky	√		
Louisiana			√
Maryland	√		
Mississippi	√		
Missouri		√	
North Carolina	√		
Oklahoma		√	
South Carolina	√		
Tennessee	√		
Texas			√
Virginia	√		
West Virginia			√

Note: Most states produced all three outreach brochures for use statewide. South Carolina and Tennessee did not produce the "Facts for Employers" brochure.

Source: Southern Institute on Children and Families, 1998.

Use of the information outreach brochures provides strong evidence that states in the South intend to be proactive in getting messages to low income families about the availability of health coverage and other benefits. While the outreach brochures are especially helpful to families leaving welfare for work, states indicate that the brochures will also be used in their efforts to reach out to families who have no connection with welfare and in their job development efforts with employers.

Information Outreach Videos

Six information outreach videos were developed through this project. The videos are designed to be used in conjunction with the information outreach brochures.

Each state that uses the information outreach brochures has been provided the following videos and has been advised that they can make additional videos or they can order them from the Southern Institute at cost:

- 5 training videos to educate local social services staff on the use of the brochures and the videos.
- 25 videos of the English version of ***Leaving Welfare for Work Isn't As Scary As It Seems*** and five of the Spanish version videos.
- 25 videos of the English version of ***Have You Heard About Benefits for Working Families???*** and five of the Spanish version videos.
- 25 ***Facts for Employers*** videos.

Two focus groups were held in South Carolina to test the video, ***Have You Heard About Benefits for Working Families???*** Focus group participants were parents of children who were income eligible for Medicaid, but not enrolled in Medicaid. Results indicated that the messages in the video effectively communicated that health coverage and other benefits are available to low income families and these benefits are available to working two parent families in addition to single parents. For many participants, these points were new information.

Participants suggested many possible viewing sites for the video. "Doctor's office" was the most frequent response. Other suggestions included hospitals or emergency room waiting areas, government offices such as social services agencies and health departments, libraries, schools, PTA meetings, women's shelters, churches, post offices, work break rooms and low income housing areas.

The video was positively associated with a feeling of encouragement. Many participants said they themselves could benefit from the new information and/or that they had friends who could benefit from the information.

CHAPTER 3
CHILD HEALTH COVERAGE

The majority of uninsured children live in families where at least one parent was employed full time at low wages.[2] Even if dependent health coverage is available through the workplace, which it often is not for low income workers, it is financially out of reach for these families.

Since the mid-1980s, public policy initiatives have been enacted to provide opportunities for poor and low income families to obtain Medicaid coverage for their children without requiring the families to be on welfare. The first major step was taken in 1986, when Congress passed an amendment to allow nonwelfare pregnant women and infants to age one to be eligible for Medicaid. Leadership for this significant and progressive change in national public policy emanated from the southern states as they sought ways to reduce the high number of infant deaths and disabilities occurring in the South.[3]

Since 1986, additional amendments have increased Medicaid age and income eligibility levels to allow more children in low income working families to be eligible for Medicaid. This group of children is often referred to as "poverty related" children because their Medicaid income eligibility levels are based on a specific percentage of the federal poverty level, rather than a relationship to welfare.

Table 7 displays the federal minimum Medicaid age and income eligibility levels for poverty related children as of October 1997. Each year, federal law requires that the age level for children under poverty be increased by one year. Currently, all children through age 13 in families with income below poverty are eligible for Medicaid. By year 2002, all children 18 and younger under poverty will be Medicaid eligible. However, states are not prohibited from taking action

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[2] General Accounting Office, New Strategies to Insure Children, (Washington, DC: US General Accounting Office, GAO/HEHS-96-35, January 1996) p. 4.

[3] Southern Regional Task Force on Infant Mortality, Final Report for the Children of Tomorrow, (Washington, DC: Southern Governors' Association, November 1985).

immediately to accelerate the phase in of coverage for children ages 14 through 18 so as to provide Medicaid coverage for all children under poverty. States can accelerate the phase in and even establish higher eligibility levels for children by simply amending their State Medicaid Plan. A federal waiver is not required.

TABLE 7
FEDERAL MINIMUM MEDICAID AGE AND INCOME ELIGIBILITY LEVELS, 1997
(Expressed As a Percentage of the 1997 Federal Poverty Level)

Age	Federal Poverty Level	Annual Income (Family of Three)
Birth to Age 1	133%	$17,729
Age 1 - 5	133%	$17,729
Age 6 - 13*	100%	$13,330

*On October 1 of each year, federal law requires that the age limit advance by one year until 18 year old children are included in the year 2002.

Research has shown that health insurance makes a difference when it comes to children having access to needed health care. Children without health coverage are less likely to have access to a regular source of medical care or to seek care for injuries, and are more likely to receive care in a clinic or emergency room and less likely to be appropriately immunized.[4] A Families USA report cited the following:

> Uninsured children frequently go without annual doctor visits. Almost two out of five long-term uninsured children (37 percent) have no doctor visits throughout the year -- more than two-and-one-quarter times the rate for insured children. Even young children age five years and under, who should receive annual doctor visits to monitor their growth and development, go without such care at three times the rate of insured children. When they do see doctors, long-term uninsured children are twice as likely as insured children to get care in emergency rooms.[5]

[4] General Accounting Office, New Strategies to Insure Children, 3; Linda J. Blumberg and David W. Liska, The Uninsured in the United States: A Status Report, (Washington, DC: The Urban Institute, April 1996); and Ron Pollack, Cheryl Fish-Parcham, and Barbara Hoenig, Unmet Needs: The Large Differences in Health Care Between Uninsured and Insured Children, (Washington, DC: Families USA, 1997).

[5] Pollack, Fish-Parcham, and Hoenig, 1.

Studies have also shown that children with public health coverage such as Medicaid have comparable access to children who have private coverage.[6]

For low income families, affordability of child health coverage is a major impediment to their children having access to preventive and primary health care. As shown in Table 8, in the South, 65% of all uninsured children live in families with income at or below 200% of the federal poverty level.[7]

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[6] U.S. Congress, Office of Technology Assessment, Healthy Children: Investing in the Future, OTA-H-345 (Washington, DC: U.S. Government Printing Office, February 1988), 17; Alan C. Monheit and Peter J. Cunningham, "Children Without Health Insurance," The Future of Children vol. 2 no. 2 (Winter 1992): 154-170; The Uninsured in the United States: A Status Report, 5.

[7] Sarah C. Shuptrine and Vicki C. Grant, Uninsured Children in the South, Second Report, (Columbia, SC: Southern Institute on Children and Families, November 1996) p. 10.

TABLE 8
DISTRIBUTION OF UNINSURED CHILDREN BY FAMILY INCOME AS RELATED TO THE 1993 FEDERAL POVERTY LEVEL

Area	Less Than or Equal to 100%	101% - 200%	Greater Than or Equal to 201%
Alabama	38%	29%	33%
Arkansas	28%	46%	25%
Delaware	8%	53%	38%
District of Columbia	47%	38%	14%
Florida	25%	37%	38%
Georgia	18%	32%	50%
Kentucky	34%	19%	47%
Louisiana	53%	26%	21%
Maryland	10%	39%	51%
Mississippi	28%	37%	34%
Missouri	21%	45%	34%
North Carolina	14%	33%	54%
Oklahoma	34%	43%	23%
South Carolina	35%	30%	35%
Tennessee	20%	34%	47%
Texas	29%	43%	28%
Virginia	8%	49%	43%
West Virginia	28%	26%	46%
SOUTHERN STATES	28%	37%	35%
UNITED STATES	25%	35%	40%

Source: Southern Institute on Children and Families (1994 CPS).

This chapter presents a discussion of issues that impede access to health coverage for low income children. Although the focus is on Medicaid, the issues are relevant to the design of other state health coverage programs for children. Every effort has been made to simplify the discussion of some very technical issues. Reading about it is difficult enough, but for families trying to navigate

the complicated eligibility system with minimal assistance, it can be overwhelming. The emphasis is on the critical need to implement effective outreach and also to simplify the application process. Even if families are better informed about their options, difficult application procedures will still impede their access to health care programs for which they are qualified.

Medicaid Income Eligibility Levels for Children

Whether provided through Medicaid or another method, the first decision is to determine the income eligibility level at which the state will assist low income working families to obtain child health coverage. Tying eligibility to some percentage of the federal poverty level has been the usual method of setting income eligibility levels. Table 9 provides percentage categories based on the 1997 federal poverty level by family size.

TABLE 9
1997 FEDERAL POVERTY LEVEL
BY FAMILY SIZE

Family Size	100%	133%	150%	185%	200%
One	$7,890	$10,494	$11,835	$14,597	$15,780
Two	$10,610	$14,111	$15,915	$19,629	$21,220
Three	$13,330	$17,729	$19,995	$24,661	$26,660
Four	$16,050	$21,347	$24,075	$29,693	$32,100

Note: Income guidelines are adjusted upward annually to reflect increases in the poverty level.
Source: Southern Institute on Children and Families.

In order for state policy makers to make informed decisions on the establishment of child health coverage eligibility levels, state data on the characteristics of uninsured children are needed, although such data are not readily available. To assist states, the Southern Institute analyzed data on uninsured children using the 1994 Current Population Survey (CPS).[8] Uninsured children in the CPS are children uninsured all year. From a regional

[8] Ibid., p. v.

perspective, it was found that in 1993, 43% of the nation's uninsured children resided in 17 southern states and the District of Columbia. The analysis found that age and income ranges which had the lowest percentages of uninsured children coincided with Medicaid age and income ranges. Some of the other findings are presented below:

- Uninsured children as a percentage of a state's population of children age 18 and younger ranged from a high of 25% in LOUISIANA to a low of 10% in MISSOURI and NORTH CAROLINA. More than one million (25%) of all uninsured children in the South lived in TEXAS.
- In 12 southern states, less than one third of uninsured children lived in families with income at or below the poverty level.
- Older children in the South were much more likely to be uninsured than children age five and younger.

During the Southern Institute state site visits in the spring and summer of 1997, attention was focused on the magnitude of the problem of uninsured children in the southern states. At that time, three southern states (**ARKANSAS, OKLAHOMA** and **SOUTH CAROLINA**) had recently initiated Medicaid expansions for children in low income working families. A few additional states were looking at expanding Medicaid or creating other opportunities for child health coverage. Nine states (**DELAWARE, KENTUCKY, MISSOURI, NORTH CAROLINA, OKLAHOMA, SOUTH CAROLINA, TENNESSEE, TEXAS** and **WEST VIRGINIA**) and the **DISTRICT OF COLUMBIA** had expanded or were considering expansions of Transitional Medicaid programs to provide longer periods of Medicaid coverage for families leaving welfare for work.

A survey was conducted to collect information on Medicaid age and income levels for children in the 17 southern states and the District of Columbia as of September 1997. The results are displayed in Table 10 and are summarized as follows:

- Two southern states (**ARKANSAS** and **SOUTH CAROLINA**) had implemented significant Medicaid expansions to provide health coverage for more children through the age of 18 in low income working families.

- Five states (**GEORGIA, MISSOURI, NORTH CAROLINA, VIRGINIA** and **WEST VIRGINIA**) had accelerated the federal phase in of children so as to provide Medicaid coverage for all children under 100% of the federal poverty level.

- Nine states (**ALABAMA, FLORIDA, KENTUCKY, LOUISIANA, MARYLAND, MISSISSIPPI, OKLAHOMA, TENNESSEE** and **TEXAS**) and the **DISTRICT OF COLUMBIA** had not accelerated the federal phase in of children under 100% of the federal poverty level. Thus, the Medicaid eligibility level for children ages 14 through 18 in these states was the welfare income eligibility level in effect on July 16, 1996.

- **TENNESSEE** allowed specified uninsured children who were not Medicaid eligible to buy into the TennCare program based on a sliding scale.

TABLE 10
MEDICAID ELIGIBILITY LEVELS FOR CHILDREN
SOUTHERN REGION, SEPTEMBER 1997
(Displayed as a Percentage of the 1997 Federal Poverty Level)

Area	Birth to 1	Ages 1-5	Ages 6-13	Ages 14-18[b]
Federal Minimum	**133%**	**133%**	**100%**	**None**
Alabama	133%	133%	100%	15.2%
Arkansas[c]	**200%**	**200%**	**200%**	**200%**
Delaware	**185%**	133%	100%	**100%**
District of Columbia	**185%**	133%	100%	38%
Florida	**185%**	133%	100%	28%
Georgia	**185%**	133%	100%	**100%**
Kentucky	**185%**	133%	100%	48.6%
Louisiana	133%	133%	100%	17.6%
Maryland	**185%**	**133%**[d]	**100%**[d]	34.5%
Mississippi	**185%**	133%	100%	34%
Missouri	**185%**	133%	100%	**100%**
North Carolina	**185%**	133%	100%	**100%**
Oklahoma	**150%**	133%	100%	47.7%
South Carolina	**185%**	**150%**	**150%**	**150%**
Tennessee[e]	**185%**	133%	100%	53.2%
Texas	**185%**	133%	100%	17%
Virginia	133%	133%	100%	**100%**
West Virginia	**150%**	133%	100%	**100%**

Notes:
a) The shaded areas indicate income levels or ages higher than the federal minimum.
b) For ages 14-18, percentages below 100% of the federal poverty level are state Aid for Families with Dependent Children (AFDC) eligibility levels as of July 16, 1996.
c) Arkansas has a Medicaid waiver to provide benefits to uninsured children with incomes below 200% who are not Medicaid eligible. Covered services for the expanded group differ from the regular Medicaid program.
d) Maryland has a Medicaid waiver to provide primary care benefits only to children in these age groups with incomes in excess of these percentages, but no higher than 185%.
e) Tennessee has a Medicaid waiver which allows specified uninsured adults and children who are not Medicaid eligible to buy TennCare coverage on a sliding scale.
Source: Southern Institute on Children and Families, Southern State Survey, October 1997.

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Effective October 1997, the new Title XXI State Children's Health Insurance Program (CHIP) was implemented. The enactment of this new federal initiative gives states enhanced federal matching dollars to provide health coverage for low income, uninsured children through Medicaid expansions or a state health coverage program.

According to the National Governors' Association, as of January 12, 1998, four southern states (**ALABAMA, FLORIDA, MISSOURI** and **SOUTH CAROLINA**) had submitted CHIP implementation plans to HCFA. Listed below is information on these expansions in health coverage for children.

- **ALABAMA** plans to expand Medicaid to all children through age 18 below the federal poverty level. (Effective February 1, 1998.)
- **FLORIDA** plans to expand Medicaid to all children through age 18 below the federal poverty level. The Healthy Kids program will subsidize premiums for Healthy Kids benefits for children at or below 185% of the poverty level. (Effective January 1, 1998.)
- **MISSOURI** plans to expand Medicaid to children through age 18 up to 300% of the federal poverty level. (Effective July 1, 1998.)
- **SOUTH CAROLINA** expanded Medicaid coverage to all children through age 18 at or below 150% of the poverty level. (Effective August 1, 1997.)

Medicaid Age Groups for Children

As shown in Table 10 above, state Medicaid income eligibility levels vary by children's ages. The major reason for the age and income differences is the piecemeal manner in which the federal expansions were created. The differing age and income levels create a confusing and often disheartening situation for families with children of multiple ages. States must decide whether children's ages will matter when it comes to health coverage.

It is difficult for both families and providers to understand why Medicaid income eligibility levels for children vary by age. Age makes no difference in children's need for health coverage. For providers, having health coverage differences among children in the same family poses problems related to charging for care for uninsured siblings. Some physicians have indicated that

they were hesitant to become the primary care provider for a family where some children had health coverage and others did not have coverage.

To achieve equity among children in the same family, to reduce confusion about coverage groups and to foster good provider relationships, Medicaid expansions or state health coverage programs need to be designed to achieve uniformity across age groups and income levels. In doing so, states must be cautious not to adversely affect children in the younger age groups who are Medicaid eligible at higher income levels. **ARKANSAS** has achieved uniformity across all age groups. **SOUTH CAROLINA** has achieved uniformity for children ages one through 18 and maintained 185% of the federal poverty level for infants to age one.

Section 1931 Medicaid Eligibility

Prior to welfare reform, families who were eligible for welfare were automatically eligible for Medicaid. The passage of welfare reform severed this automatic link.

During the welfare reform debate, concern was expressed regarding the need to maintain Medicaid coverage for families receiving AFDC at the time welfare reform was enacted. There was also a desire to give states an additional opportunity to provide Medicaid coverage for both children and parents in low income families. As a result, Section 1931 of the Medicaid law created a new Medicaid eligibility category to provide Medicaid coverage for families who meet a state's AFDC eligibility requirements in effect on July 16, 1996, shortly before welfare reform legislation passed Congress.

States must now determine how to deal with two separate eligibility determinations, one for welfare and another for Medicaid. This does not mean that states have to use a separate application process and no southern state indicated the desire to do so. However, when the eligibility criteria differs between the Section 1931 rules and the new state welfare rules, administrative complexity is added to an already complicated process.

During the site visits discussions, it was apparent that states were struggling to find an efficient way to provide Medicaid coverage for families who receive welfare. Many states were experiencing difficulty in doing so because they had enacted or were preparing to enact more liberal eligibility criteria for welfare families than the state's welfare criteria in effect on July 16, 1996, particularly in the area of allowed assets and the deprivation requirement.

All but a few states provided assurances that when families applied for welfare, they were being informed of Medicaid coverage opportunities without welfare. Those that could not make such assurances at the time indicated that plans to inform families were underway.

As discussed in Chapter 2, it is essential that families applying for welfare and those receiving welfare understand that they do not have to receive cash assistance to receive Medicaid coverage. In particular, for children ages 14 through 18 in the nine southern states that have not accelerated the Medicaid age related phase in for children under poverty (see Table 10 above), coverage under Section 1931 may be the only way they can obtain Medicaid coverage without being on welfare unless a state also has a Medically Needy program.

While the southern states did not want to return to automatic eligibility, all states indicated that they would like to have the option to create a Medicaid category that is a mirror image of their state's welfare criteria under the TANF block grant so that they would be able to link welfare families to Medicaid eligibility without the need for a separate eligibility determination.

Asset Testing

An additional state decision regarding eligibility for child health coverage is whether to disallow assistance to income eligible families who have assets such as a savings account and automobile. Federal law gives states the option to not impose an asset test in determining Medicaid eligibility for children.

Most states do not conduct an asset test for children. In the South, only **ARKANSAS** and **TEXAS** conduct asset tests for children's Medicaid. **OKLAHOMA** recently took action to eliminate asset testing effective December 1, 1997.

Transitional Medicaid

Transitional Medicaid benefits are provided to families who leave welfare due to increased earnings. Federal law states that families are entitled to Transitional Medicaid coverage for six months regardless of income and for an additional six months if their income does not exceed 185% of the federal poverty level.

Discussions during the site visits indicated that when families lose Transitional Medicaid in the second six months, it is usually not because their income exceeded 185% of the poverty level. The major reason for loss of Transitional Medicaid benefits is because families did not comply with reporting requirements related to verification of income. These reporting requirements are burdensome for families, employers and eligibility agencies and have little merit with regard to quality control. During site visit discussions, all states indicated that they would like to have the option to provide Transitional Medicaid benefits for 12 months without interim reporting requirements.

Federal law also requires as a condition of eligibility for Transitional Medicaid that families actually receive cash assistance for at least three months of the preceding six months. In effect, this rule encourages families to apply for welfare in order to obtain Medicaid coverage for their family. All states indicated that they would like to have the option of eliminating this rule.

States recognize that providing Medicaid coverage during a transitional period is an important strategy for welfare reform. However, an issue related to Transitional Medicaid is that it is time limited rather than income based. Benefits are terminated at a specific time regardless of the family's ability to pay for health coverage at that point.

As reported above, at the time of the site visits, nine southern states and the District of Columbia had increased or were giving consideration to increasing the time period for receipt of Transitional Medicaid. However, Southern Institute interviews and focus groups with families have identified time limited benefits as discouraging to families leaving welfare for work. Their clear message is that they would like to see benefits of all types available on a sliding

income scale so that they earn out of the range of eligibility rather than having benefits expire due to an arbitrary time limit.

After the expiration of Transitional Medicaid, it is likely that the children will still be eligible for Medicaid, especially if they are in the younger age groups where income eligibility levels are higher. For very low wage workers, however, having coverage for parents as well as children is important for the family's well being.

Two southern states have created programs to provide health coverage for adults. **DELAWARE** provides health coverage through the Diamond State Health Plan to uninsured individuals with incomes below the poverty level. **TENNESSEE** allows both children and adults in low income families to buy into Medicaid. Both states had to obtain federal 1115 waivers to enact their programs.

During site visit discussions, several states indicated a desire to be able to provide Medicaid benefits on a sliding income scale without having to go through what they consider to be an ordeal to obtain a federal Medicaid waiver.

State Child Health Coverage Strategies

During the site visit discussions, strategies implemented by southern states to expand health coverage for children in low income families were identified. Summaries of five state approaches are outlined below and state contacts are provided for further information.

Arkansas

An initiative of Governor Mike Huckabee, the ARKids First program was implemented in September 1997 to provide health coverage to working families who earn too much to be eligible for Medicaid, but cannot afford to purchase their own health insurance. ARKids is available to children through age 18 with income at or below 200% of the poverty level.

ARKids required a Medicaid 1115 waiver since it provides a limited benefits package and families are charged a small copayment for services. There is no resource test under ARKids.

Funding for ARKids is provided by $11 million in state Medicaid dollars and $33 million in federal Medicaid matching funds.

An aggressive marketing campaign is underway to reach out to eligible families. (See the Outreach program summary below for more information.) As of January 1998, 10,000 children were enrolled in the program.

Contact: William Freeburn
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PO Box 1437
Little Rock, AR 72203
501/682-8303
bill.freeburn@medicaid.state.ar.us

Florida

Healthy Kids is a non-Medicaid health insurance program offered through public schools. Currently, Healthy Kids is operating in 19 of Florida's 67 counties with over 47,000 children enrolled in the program. Children enrolled in the National School Lunch Program are deemed eligible for subsidized coverage. Those eligible for the program are uninsured children ages five through 18 who are enrolled in school and who are not eligible for Medicaid. Some counties have extended eligibility to pre-school children or younger siblings.

To reach children who are eligible for the program, Healthy Kids relies on the school system. On the first day of an open enrollment period, an application is sent home with the children. Applications are also sent home with report cards, with PTO meeting announcements and other materials that the school uses to communicate with the families. Included with the application is a self addressed envelope that families send directly to the Healthy Kids corporate office in Tallahassee.

All applications are forwarded to a Third Party Administrator (TPA) who creates an electronic record for the account. Electronic matches are made with the school systems and the State of Florida to verify age, school enrollment, and lack of Medicaid enrollment. Current efforts are underway to coordinate more closely with Medicaid to assure that children are appropriately referred. Matches are also made with the school system to verify participation in the National School Lunch Program. Children who are determined eligible for Healthy Kids are sent a letter from the TPA announcing the effective date of health coverage.

Healthy Kids is also promoted through radio and television public service announcements that can be utilized by counties during an open enrollment period. In addition, counties may elect to create a marketing program that includes billboards, newspaper advertisements, flyers and tray liners for fast food restaurants.

Contact : Jana Key
Florida Healthy Kids Corporation
223 S. Gadsden Street
Tallahassee, Florida 32301
850/224-5437
jkey@healthykids.org

South Carolina

In September 1997, Governor David Beasley announced the Partners for Healthy Children initiative which increased the income eligibility level for Medicaid to 150% of the poverty level for children ages one through 18. It is anticipated that the initiative will provide Medicaid coverage to an additional 75,000 children in South Carolina.

Funding for Partners for Healthy Children is being provided by a public-private partnership. State Medicaid match of $3 million was contributed by three children's hospitals in South Carolina (Greenville Hospital System, Medical University of South Carolina and Richland Memorial Hospital). The South Carolina Department of Health and Human Services allocated $1 million and $2 million was appropriated by the South Carolina General Assembly. The state contributions will draw down federal Medicaid matching funds to provide a total program of over $31 million. (See the Outreach program summary below for more information.)

Contact : Kelly Lineweaver
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lineweav@dhhs.state.sc.us

Tennessee

The TennCare Program has been operating under an 1115 waiver since January 1, 1994. Initially TennCare provided health coverage to all uninsured who did not have access to health insurance. In January 1995, enrollment was closed to the uninsured but remained open to the Medicaid population and uninsurables.

Effective April 1, 1997, TennCare opened enrollment for children under age 18 who did not have access to insurance through their parents' or guardians' employers. It was estimated that as many as 50,000 children would qualify under the open enrollment. As of December 7, 1997, 24,916 children had enrolled.

On January 1, 1998 an expansion occurred to include all children under 19, regardless of access to insurance, if the family's total income is below 200% of poverty. The open enrollment period for children below 200% of poverty will remain in effect until March 30, 1998. Open enrollment for children without access to health coverage will continue indefinitely.

Contact: Keith Johnson
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Bureau of TennCare
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Nashville, TN 37247-6501
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kjohnson3@mail.state.tn.us

Virginia

In order to make health care coverage available to working families, Virginia offers a Health Insurance Premium Payment (HIPP) program. It was established in 1991 within the Department of Medical Assistance Services (Medicaid). Through HIPP, Medicaid funding is used to pay the health insurance premiums. After being approved for Medicaid and determined eligible for HIPP according to state regulations, the entire family may be covered. This program is allowed under Medicaid as long as it is cost effective and in accordance with Health Care Financing Administration regulations.

Every application for Medicaid is accompanied by an application for HIPP, providing there is evidence of insurability. Applications, employer verification forms and the medical history questionnaire are checked for accuracy at the Department of Social Services level. They are sent to the HIPP Unit at Medicaid. HIPP staff verify all necessary information with the employer. This may include but is not limited to types of plans, availability, premium amounts, eligibility and dates.

The cost of the group health insurance package is compared with the cost of the Medicaid managed care capitation plan. If the cost of the group health insurance package demonstrates savings on an annual basis, then the applicant is requested to enroll in HIPP. Medical utilization review and health insurance costs are taken into consideration when calculating cost effectiveness.

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dgiffin@dmas.state.va.us

Medicaid Eligibility Outreach

Despite state initiatives to provide Medicaid coverage opportunities for more low income children, there are approximately three million children who are eligible for Medicaid, but are not enrolled.[9] Therefore, state policy makers should not consider the job done when they raise Medicaid eligibility levels or create a state child health insurance program. Special attention must be given to outreach and eligibility simplification if the intent of expansions is to be realized. Outreach issues and strategies are discussed below.

State Outreach Strategies

State outreach initiatives were a major topic of discussion on the state site visits. While there are some exemplary programs that have been implemented in the South, outreach initiatives were not underway in most states. Five statewide eligibility outreach initiatives are summarized below and contact information is provided.

Arkansas

On September 1, 1997, ARKids First was implemented to provide health coverage to working families who earn too much to be eligible for Medicaid, but cannot afford to purchase their own health insurance. ARKids is available to children through age 18 with income at or below 200% of the poverty level. Outreach efforts to promote the new program include the following:

- Providers, such as physicians, dentists, hospitals, school systems, rural health clinics and federally qualified health care centers, assist in promoting the program.
- An advertising campaign was developed for TV, radio and newspaper.
- Information was placed in Arkansas Department of Human Services (DHS) county offices, libraries, and on food trays in McDonald's restaurants and in their carry out meals.
- Speaker bureaus were established to provide local community contact through organizations such as the Lions Club, Rotary Clubs and other community interest groups.

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[9] General Accounting Office, Health Insurance for Children: Private Insurance Coverage Continues to Deteriorate, HEHS-96-129, June 17, 1996.

- Toll free numbers were established and staff was hired to receive requests for materials and applications.
- Applications that are easy to read and understand were developed.

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Georgia

The Right from the Start Medicaid (RSM) Project began in July 1993 as Governor Zell Miller's response to Georgia's high infant mortality rate. The project was created to address the need to improve health care access for all children and pregnant women.

Through an agreement with the Georgia Department of Medical Assistance and the Georgia Department of Human Resources, eligibility workers are placed in health departments, hospitals, clinics, schools, day care centers, community action agencies and other locations in local communities. A major feature of the program is availability of staff during non-traditional hours so that applicants can apply for RSM without having to lose time from their jobs or from school. Non-traditional hours are defined as any time other than 8:00 AM to 5:00 PM, Monday through Friday.

The application process for RSM is quick and easy. Verification requirements are limited and RSM workers are trained to assist applicants in obtaining the verification they need to become enrolled in RSM.

Workers and supervisory staff make presentations regularly to community groups, medical providers and employers. Since 1994, RSM staff have made over 33,000 presentations. RSM staff have utilized creative techniques for distributing information to the public. Some examples include: flyers sent home with school children, program information in women's and children's shoe boxes, visits to day care centers, and brochures on pizza boxes delivered to homes. Employer contacts have resulted in opportunities to distribute literature through personnel offices and at employee forums, and to accept applications at job sites.

Additionally, Georgia is using the Southern Institute information outreach brochures statewide.

Contact : Becky Shoaf
Georgia Department of Human Resources
Division of Family and Children Services
Two Peachtree Street, NW (16-400)
Atlanta, GA 30303
404/657-4085

South Carolina

To assure that eligible children become enrolled in South Carolina's Medicaid expansion program, Partners for Healthy Children, the South Carolina Department of Health and Human Services created a centralized eligibility system to give applicants new opportunities for filing applications. Parents can obtain applications from schools, doctors' offices, neighborhood pharmacies, local health clinics, child care centers and nearby hospitals, as well as typical governmental sources such as the county Department of Social Services. Applications are mailed to a central location, where eligibility is quickly determined.

A simplified application, which includes a straightforward income eligibility chart, was designed especially for children's Medicaid. McLeod Regional Medical Center participated in the printing of approximately 500,000 applications. (See Appendix D for a copy of the application.)

Additionally, South Carolina is using the Southern Institute information outreach brochures statewide.

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lineweav@dhhs.state.sc.us

Tennessee

Effective April 1, 1997, the TennCare program opened enrollment to uninsured children up to age 18 who do not have access to insurance through parents' or guardians' employers. It was estimated that as many as 50,000 children would be eligible. The following outreach efforts were launched to enroll as many of the 50,000 children as possible:

- Letters and applications were sent to children on Food Stamps who were not enrolled in TennCare.

- Letters and applications were sent to families with children under age 18 who had previously been denied for TennCare due to closed enrollment for the uninsured.

- A letter and flyer were sent to all school boards, every school superintendent, school principals, school nurses, all Head Start programs, licensed day care centers, and Medicaid providers on file.

- Local health departments sponsored county meetings where a video on open enrollment for children was presented.

- A letter and flyer were sent to all employers on file with the Department of Labor. (Federal, state and large corporate employers were excluded.)

- The American Association of Retired Persons agreed to put an article in their newsletter asking members to get the word out to their families, neighbors, and friends that might have or know of children who would be eligible.

Additionally, Tennessee is using the Southern Institute information outreach brochures statewide.

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kjohnson3@mail.state.tn.us

West Virginia

West Virginia is taking the following actions to improve access to Medicaid for children and families.

- At the beginning of each school year, each child is provided an enrollment form for their school lunch program. Through a cooperative effort with the Department of Health and Human Resources (DHHR), the form also provides a check off which gives the county school system permission to refer the parent or guardian to the county DHHR office. The county office in turn contacts the family, providing information on Medicaid coverage for all family members. Additionally, school based speech, occupational and physical therapists and school psychologists are oriented to the Medicaid eligibility process. They can make direct referrals to the county DHHR office for children whose parents desire such a referral.

- A streamlined Medicaid application has been developed and is available in physicians' offices, hospitals, clinics, and West Virginia's Comprehensive Behavioral Health Centers.
- The Family Matters Hotline provides information and referral services to all families and providers in West Virginia. The hot line is toll free and available 24 hours a day.

Contact : Jack Frazier
West Virginia Bureau for Medical Services
7012 MacCorkle Avenue, SE
Charleston, WV 25304
304/926-1724

Medicaid Application Process

The success of efforts to reach out to families to let them know about health coverage opportunities for their children will be limited without also taking action to simplify the application process. If the application process is intrusive and creates embarrassment for families, many families will simply turn away. Some may form lasting impressions that will keep them from trying again.

Medicaid eligibility determinations are typically conducted in a bureaucratic atmosphere amidst many illogical eligibility rules and procedures. Families often describe the application procedures and requirements as demeaning. It is likely that the process of applying contributes significantly to the reported stigma associated with Medicaid. And many eligibility workers are just as frustrated as the applicants with all of the rules and regulations. The following statement by an eligibility worker in a previous study provides some insight:

> *You can either be a paper worker or a social worker, but it is difficult to be both with these caseloads and requirements...It would be great to have more discretion, but what happens when you use the wrong discretion?...Performance reviews are focused on reducing errors and on the standard of promptness. There is no discussion of who you helped.*[10]

[10] Sarah C. Shuptrine and Vicki C. Grant, Assessment of the Medicaid Eligibility Process in Chatham County, Georgia, (Columbia, SC: Sarah Shuptrine and Associates, June 1991) p. 13.

Simplification of the process by which families file applications is a critical component of serious efforts to help children gain access to Medicaid or other health coverage programs. To decrease the eligibility barriers and increase the likelihood that eligible children can become enrolled will require state and local eligibility agencies to undertake a comprehensive review of current policies and procedures with the clear intent of making benefits more accessible.

Many of the policies and procedures that govern the Medicaid application process evolved from the welfare eligibility rules. While the Medicaid application process has become somewhat more user friendly in recent years, it is important to deal directly with some of the welfare policies that have influenced the Medicaid eligibility process for children, particularly verification requirements.

During the 1980s, federal and state policies communicated strong messages to local welfare agencies to direct more and more attention to keeping ineligible people from receiving assistance. There was no counterbalancing message to agencies to help eligible persons obtain benefits. Major resources were allocated for "quality control" measures that placed primary attention on errors that resulted in *ineligible* families receiving benefits. Little attention was given to the errors that resulted in *eligible* families being denied benefits. Few or no resources were directed to development of outreach systems to assist families who had difficulty obtaining the many required verification documents. Rather than promoting a balanced approach to eligibility services, this eligibility services environment favored denials.

One indicator of the extent of eligibility barriers present in the welfare program is the percentage of denials issued for procedural reasons rather than for reasons related to eligibility criteria, e.g., excess income. An analysis of AFDC (welfare) eligibility data for federal fiscal year 1996 is enlightening. It shows that almost one-third (31%) of families applying for welfare were denied. Of the denials, over half (55%) were due to what is recorded as applicant failure to comply with procedural requirements. At the time, AFDC eligibility resulted in automatic eligibility for Medicaid, so these families were also denied Medicaid

coverage. Appendix E contains state by state data on AFDC application denials for 1996.

In the early 1990s, Congress directed that Medicaid quality control policies for poverty related groups take into account the need to measure both inappropriate approvals *and* inappropriate denials of eligibility. However, by the time this new policy direction was provided, the mindset that had produced numerous complicated rules for eligibility workers and numerous verification requirements for families had become well established. To bring some balance to eligibility services, new concepts and policies must be envisioned and implemented.

On the state site visits, meetings were held with state and local eligibility staff to examine Medicaid and welfare related eligibility policies and procedures. Extensive discussions were held to identify application procedures that can impede access to health coverage, especially those procedures that relate more to welfare than to Medicaid. Additionally, strategies to make the application process more user friendly were identified. Findings and strategies are discussed below.

Application Locations

In the Omnibus Budget Reconciliation Act of 1990, the Medicaid law was amended to require states to accept and begin processing applications for pregnant women and children at locations other than those used for welfare. These locations included "disproportionate share" hospitals and federally qualified health centers.

States were asked to identify the locations other than welfare agencies where applications could be filed. Outstationing practices varied considerably across the states. There was confusion in some states regarding the ability of providers to contribute to the state Medicaid match needed to implement outstationing.

Many states reported some outstationing of eligibility staff at hospitals, typically at regional hospitals, federal health centers and health departments. In some instances, the state Medicaid match for outstationed staff has been

provided by the hospitals where staff are located. **ALABAMA** reported that Medicaid eligibility staff are outstationed in all health departments.

LOUISIANA reported the establishment of 400 Medicaid application sites throughout the state, including rural health clinics, community action agencies and application centers. Employees of application centers are required to complete a four day training session. At the application centers, Medicaid applications are taken and then forwarded to the Medicaid agency for a determination.

Face-to-Face Application Requirements

Face-to-face interviews can be problematic for working families, especially those who do not get paid unless they are on the job. During site visit discussions, states were asked if they allow families to apply for Medicaid by mail or telephone and whether state policy requires face-to-face interviews. Most states allow applications to be submitted by mail and many states also allow submission by telephone. Eight states (**ALABAMA, ARKANSAS, FLORIDA, MISSOURI, SOUTH CAROLINA, TENNESSEE, VIRGINIA** and **WEST VIRGINIA**) and the **DISTRICT OF COLUMBIA** do not require face-to-face interviews.

Verification Requirements

Studies have documented the extent to which verification requirements restrict access to Medicaid. Written verification of income, age, citizenship, family composition and other items often require considerable time and resources to collect and frequently applicants must rely on third parties to provide the required documentation within a tight time period. These third parties, such as employers or family members who may be making a small cash contribution to help the family, may or may not be cooperative.

The process of obtaining verification requirements is often considered demeaning by families seeking health coverage for their children. Verification is an area where states have flexibility. States make the decisions regarding which items must be verified by a document, which items can be self declared

and the extent to which eligibility workers are given discretion. Generally, the process is regimented and little discretion is given to eligibility workers. Typically, when the applicant fails to return all required verification within the specified time, the application is denied for procedural reasons.

Agency initiatives to review verification requirements are essential to making the application process more private and more user friendly. An agency review of verification requirements should include the following:

- Determining federal eligibility verification requirements and differentiating those requirements from additional state and local requirements.
- Reviewing the need for verification, item by item, giving special attention to the value of specific documents from a quality control standpoint.
- Identifying alternative documents for verification.
- Determining verification that can be obtained through federal, state or local systems rather than requiring the applicant to provide it.

When attention is given to reducing the percentage of denials due to procedural reasons, improved eligibility outcomes have been achieved. Some examples are:

- In **GEORGIA**, an eligibility simplification and outreach program operated by the Chatham County Department of Family and Children Services reduced the application denial rate from 61% in 1991 to 29% in 1993. Procedural denials were reduced from 67% to 16%.[11]
- In **SOUTH CAROLINA**, a Medicaid outreach program operated by the Charleston County Department of Social Services reduced a 70% denial rate to 18%, with procedural denials dropping from 48% to 3%.[12]

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[11] Sarah C. Shuptrine, Vicki C. Grant and Genny G. McKenzie, Addressing the Need for Outreach to Pregnant Women and Children in Georgia, (Columbia, SC: Sarah Shuptrine and Associates, March 1994) p. 13.

[12] Ibid., p. 13.

Income Verification. Table 11 shows the results of research conducted in Atlanta, Georgia on procedural denials of pregnant women and children applying for Medicaid. The table represents an unduplicated count of the number of different documents requested of each applicant and not returned.[13] As shown, wage related information, such as check stubs or employer statements, is the information most likely not to be returned by applicants. Employer cooperation is critical to the family's ability to verify information on the application if payroll stubs are not issued or the family did not retain their check stubs for the required period of time.

ARKANSAS reported that a new state law requires employers to report income in 20 days and that this information is used to verify that recipients are leaving welfare for work. **GEORGIA** allows self declaration of income for families with income below the poverty level and has not experienced increases in error rates using this method of verification.

One study examining issues related to procedural denials reviewed 100 randomly selected cases denied for procedural reasons to determine the likelihood that the family met income criteria. The review of cases denied for procedural reasons showed that 77% of the denied applicants were likely to be financially eligible.[14]

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[13]Sarah C. Shuptrine, Vicki C. Grant and Genny G. McKenzie, Improving Access to Medicaid for Pregnant Women and Children, (Columbia, SC: Sarah Shuptrine and Associates, February 1993) p. 24.

[14] Ibid., p. 37.

TABLE 11
NUMBER AND PERCENTAGE OF DOCUMENTS NOT RETURNED IN RSM

Documents Not Returned	Total Documents Not Returned	% of Documents Not Returned
Employer Related	**51**	**36%**
Check Stub/Wage Verification	39	28%
Employment Separation Notice	12	9%
Personal/Family Characteristics	**35**	**25%**
Social Security Number	18	13%
Health Insurance Questionnaire (285)	5	4%
Citizenship	4	3%
Health Insurance Information	3	2%
General Identification	2	1%
Proof of Address	1	1%
Verification of Living Arrangements	1	1%
Proof of Relationship	1	1%
Pregnancy Related	**21**	**15%**
Pregnancy Verification	13	9%
EDC	8	6%
Miscellaneous	**15**	**11%**
Child Care Expenses	3	2%
Life Insurance Information	2	1%
Copy of Lease from Apartment	2	1%
Information on Medical Insurance	2	1%
Expense Statement	2	1%
Shelter Statement	1	1%
Statement Regarding Name Change	1	1%
Work Registration Exemption	1	1%
Verification of Student Financial Aid	1	1%
Other Cash Benefits	**7**	**5%**
Proof of Application/Award for UCB	4	3%
Proof of SS Award Letter	1	1%
Final Payment of UCB	1	1%
Verify Worker's Compensation	1	1%
Contribution	**6**	**4%**
Contribution Statement	6	4%
Child Support Related	**5**	**4%**
Proof of Child Support Payment	3	2%
Information on Absent Parent	1	1%
Child Support Form (130)	1	1%
TOTAL	**140**	**100%**

Source: Sarah Shuptrine and Associates, 1994.

Age of Children Verification. Birth verification can be an expensive verification item for families applying for health coverage. Charges for birth certificates vary by state. If the child is born within the state, eligibility workers should obtain verification of birth through state vital statistics systems rather than requesting that families provide birth certificates. In 1991, **SOUTH CAROLINA** implemented a statewide birth verification system which provides a link to vital statistics. **ARKANSAS** reported that recent action has allowed eligibility workers on line access to vital statistics data for the purpose of verifying birth records.

Eligibility Worker Discretion Regarding Verification. Discussions during the site visits identified state practices regarding the extent to which eligibility workers are allowed discretion in determining when verification is necessary. Some states allow considerable discretion while others take a strict approach to verification. Table 12, Table 13, Table 14 and Table 15 provide information collected on the site visits regarding state approaches to verification.

TABLE 12 INCOME VERIFICATION REQUIREMENTS FOR MEDICAID POVERTY RELATED CHILDREN		
State	Income Verification Required in All Cases	Income Verification Required When Questionable
Alabama	√	
Arkansas	√	
Delaware	√	
District of Columbia	√	
Florida	√	
Georgia	Only when declared income exceeds 100%	Only when declared income is below 100%
Kentucky	√	
Louisiana	√	
Maryland	√	
Mississippi	√	
Missouri	√	
North Carolina	√	
Oklahoma	√	
South Carolina	√	
Tennessee	√	
Texas	√	
Virginia	√	
West Virginia	√	
Total	18	1
Source: Southern Institute on Children and Families, 1997.		

TABLE 13 AGE VERIFICATION REQUIREMENTS FOR MEDICAID POVERTY RELATED CHILDREN		
State	Age Verification Required in All Cases	Age Verification Required When Questionable
Alabama	√	
Arkansas	√	
Delaware	√	
District of Columbia	√	
Florida		√
Georgia		√
Kentucky		√
Louisiana	√	
Maryland	√	
Mississippi	√	
Missouri	√	
North Carolina		√
Oklahoma		√
South Carolina		√
Tennessee	√	
Texas	√	
Virginia	√	
West Virginia	√	
Total	12	6
Source: Southern Institute on Children and Families, 1997.		

TABLE 14 FAMILY COMPOSITION VERIFICATION REQUIREMENTS FOR MEDICAID POVERTY RELATED CHILDREN		
State	Family Composition Verification Required in All Cases	Family Composition Verification Required When Questionable
Alabama		√
Arkansas	√	
Delaware	√	
District of Columbia		√
Florida		√
Georgia		√
Kentucky		√
Louisiana	√	
Maryland		√
Mississippi		√
Missouri	√	
North Carolina		√
Oklahoma		√
South Carolina		√
Tennessee	√	
Texas	√	
Virginia		√
West Virginia		√
Total	6	12
Source: Southern Institute on Children and Families, 1997.		

TABLE 15 CITIZENSHIP VERIFICATION REQUIREMENTS FOR MEDICAID POVERTY RELATED CHILDREN		
State	Citizenship Verification Required in All Cases	Citizenship Verification Required When Questionable
Alabama		√
Arkansas		√
Delaware	√	
District of Columbia	√	
Florida	√	
Georgia		√
Kentucky		√
Louisiana	√	
Maryland		√
Mississippi		√
Missouri		√
North Carolina		√
Oklahoma		√
South Carolina		√
Tennessee	√	
Texas		√
Virginia	√	
West Virginia		√
Total	6	12
Source: Southern Institute on Children and Families, 1997.		

Verification Check Lists. A written list of required verification items that is orally reviewed during the application interview can be helpful to applicants. Notwithstanding the usefulness of "check lists," preprinted check lists that contain more items than are required for verification of a child's Medicaid application can contribute to procedural denials.

Families may misunderstand that they are required to return only the items checked. In some cases, families said they did not return any verification

items because they did not have all of the items.[15] The family has no way of knowing which items are most important. It's also helpful to have a statement that indicates that the agency is willing to provide assistance if needed.

Another issue related to check lists is that many are difficult to read and understand. **DELAWARE** has developed an attractive approach to check lists. They have utilized some color and each check list gives the date and time for the application interview appointment. The check lists, referred to as "Slim Jims," also include a statement letting applicants know to call if they need assistance.

Application Processing Period

Southern states indicated that applicants are typically given 10 days following an application interview to submit required verification unless there are unusual circumstances that would require more time. Since most states have not devoted resources to providing outreach workers to augment the eligibility worker who is normally desk bound, the eligibility worker usually has no choice but to initiate a procedural denial if the verification is not provided within the specified period.

Since many states have been sued on timeliness issues, eligibility workers are particularly attuned to the need to take quick action even if that means a procedural denial. If the applicant requests more time, it is generally allowed, but many applicants are unsure that additional time is a possibility.

Eligibility workers report that denial notices are sometimes treated as reminder notices by families and thus result in a second application being submitted, producing a reapplication. Assisting applicants to obtain required verification can reduce procedural denials and duplicative work by eligibility workers.

Maintaining Eligibility

During the site visits, the discussions included a review of procedures by which states assure that all categories of Medicaid eligibility are searched before determining a child is ineligible and that Medicaid coverage should be

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[15] Ibid., p. 30.

terminated. Most states indicated that they rely on eligibility workers to manually initiate searches for other possible categories of eligibility and to transfer the child's case if a category is found.

In five states (**FLORIDA, KENTUCKY, LOUISIANA, TENNESSEE** and **WEST VIRGINIA**) and the **DISTRICT OF COLUMBIA**, automation has made the process of searching for other Medicaid eligibility categories less burdensome and error prone for eligibility workers, while protecting children from inappropriate case closures. The West Virginia automated system, know as RAPIDS, is outlined below.

West Virginia

West Virginia has 47 Medicaid eligibility categories. Before the automated system known as RAPIDS was developed, eligibility workers were expected to manually review all eligibility possibilities. Working through a hierarchy of eligibility, the system evaluates the applicant or recipient for eligibility within the various categories and informs the worker of the results.

Contact: Roger S. Neptune, HHR Specialist, Sr.
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West Virginia Department of Health and Human Services
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Phone: (304) 348-0879
Fax: (304) 348-0875

Measuring Eligibility Outcomes

During the site visits, states were asked about the availability and use of data to measure Medicaid eligibility outcomes, particularly procedural denials. **LOUISIANA** is the only state that reported having an official policy to avoid procedural denials. Only three states (**DELAWARE, NORTH CAROLINA** and **MISSISSIPPI**) reported that they regularly review eligibility outcome data.

States were also asked whether they were seeing equivalent increases in Transitional Medicaid and poverty related children Medicaid cases as welfare rolls declined. Only two states (**DELAWARE** and **VIRGINIA**) reported equivalent increases in Transitional Medicaid and poverty related Medicaid for children as welfare rolls declined.

The Health Care Financing Administration does not require states to report Medicaid eligibility outcome data. Without a federal reporting requirement of eligibility outcome data, data on Medicaid approval rates and the reasons for denial or the extent of procedural denials are not readily available.

Actions That Can Improve Access to Child Health Coverage

Actions are needed at the state and federal levels to improve access to health coverage for low income children. Some of these actions are described below.

1) To increase the number of low income children who have health coverage, states should utilize the opportunities presented by the Medicaid program, CHIP and state/local coverage programs to design a coordinated approach to child health coverage.

   - To assure health coverage for all children living in poverty, states should accelerate the federal Medicaid phase-in for all children 18 years old and younger.

   - To prevent inequity of health coverage across age groups, states should design coverage programs for low income children to achieve uniformity in age groups and income levels.

2) To allow states to efficiently provide Medicaid coverage for children and families who are eligible under the state welfare (TANF) program, the Medicaid law can be amended to give states the option to create a Medicaid eligibility category which mirrors TANF eligibility.

3) To assure that families applying for welfare (TANF) understand that they do not have to be on welfare to obtain Medicaid coverage for their children, states should fully inform and link applicant families to health coverage opportunities, such as Medicaid poverty related children coverage, Section 1931 coverage, state CHIP coverage and other state/local coverage programs.

4) To avoid denying Medicaid coverage to children in income eligible families who have resources that exceed state asset limits, states should exempt assets when determining eligibility for child health coverage.

5) In order to reduce the chances that reporting requirements could result in income eligible families losing Medicaid benefits during the first year after leaving welfare, the federal Medicaid law can be amended to give states the option to eliminate reporting requirements in the second six months of Transitional Medicaid.

6) To avoid requiring families to spend a specified time on welfare in order to obtain health coverage, the federal Medicaid law can be amended to give states the option to eliminate the rule that requires families to receive cash assistance for three out of the previous six months in order to be eligible for Transitional Medicaid.

7) To assist low income families to access health coverage for their children, states and communities should design and implement aggressive outreach strategies.

8) To improve access to child health coverage, states and communities should identify and implement actions needed to make the application process less burdensome for families.

9) In order to avoid erroneous or premature termination of Medicaid benefits for a child, states should develop and implement information systems which assure that children are automatically transferred from one eligibility category to another without disruption to their Medicaid benefits.

10) To assure that the eligibility system is regularly examined with the goal of reducing policy and procedural barriers, states and communities should establish a periodic review process of eligibility outcome data.

CHAPTER 4
CHILD CARE ASSISTANCE

Working at a low wage job and being unable to pay for decent child care while at work is a heartpounding dilemma for many low wage families. They may be able to make arrangements with a relative or friend to get child care at a reduced cost, but often such arrangements don't last. Without some financial assistance, it is often not possible for low wage families to obtain dependable, quality child care.

Affordability of quality child care is a major public policy issue that affects both low and middle income families. However, research has shown that paying the high cost of child care is especially burdensome for low income families. Families earning below the federal poverty level spend an average of 33% of their income on child care.[16]

The push to move families from welfare to work added an urgency to the need for community, state and federal action on behalf of families who cannot afford to pay for child care on their earnings alone. The 1996 welfare reform legislation substantially increased federal funding for child care. States must provide matching funds. States can also increase funding of child care by reallocating up to 30% from the TANF block grant to the Child Care and Development Block Grant (CCDBG).

Table 16 is an excerpt of information on child care funding decisions by southern states. The table shows that all southern states planned to make use of all available federal matching dollars. Six states (**ARKANSAS, DELAWARE, GEORGIA, NORTH CAROLINA, TENNESSEE** and **VIRGINIA**) and the **DISTRICT OF COLUMBIA** planned to spend beyond the federal match. Five states (**MISSOURI, OKLAHOMA, TENNESSEE, TEXAS** and **VIRGINIA**) had transferred funds from TANF to CCDBG.

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[16] National Child Care Survey, 1990, as quoted in Sandra Clark and Sharon Long, "Child Care Block Grants and Welfare Reform," Welfare Reform Briefs, No. 15, Urban Institute, June 1995, p. 3.

TABLE 16 STATE CHILD CARE EFFORTS UNDER P. L. 104-193			
State	Will state draw down all federal money?	Will state spend beyond federal match?	Will state transfer funds from TANF to CCDBG?
Alabama	Yes	N/I	No
Arkansas	Yes	Yes - has recategorized state child care funds so they qualify as federal match	No
Delaware	Yes	Yes	No
District of Columbia	Yes	Yes - $12.3 million beyond required $6 million MOE and match	Transfer proposed by mayor
Florida	Yes	N/I	No
Georgia	Yes	Yes	No
Kentucky	Yes	No	No
Louisiana	Yes	No	No
Maryland	Yes	No	No
Mississippi	Yes	No	No
Missouri	Yes	No	Yes - has transferred $8.5 million
North Carolina	Yes	Yes - will obligate additional $22 million for early childhood initiative	N/I - transfer of $27 million pending legislative approval
Oklahoma	Yes	No	Yes - has transferred $25 million
South Carolina	Yes	No	No
Tennessee	Yes	Yes	Yes
Texas	Yes	No	Yes - transfer of $17 million in FY 98, $23 million in FY 99
Virginia	Yes	Yes	Yes - $7 million has been transferred
West Virginia	Yes (provided state can obligate funds in a way that satisfies state law)	No–but some additional state funding based on $2 million initiative from last fiscal year	No

N/I–information not included in survey response, or not yet available; **MOE**–maintenance of effort; **TANF**–Temporary Assistance for Needy Families; **CCDBG**–Child Care and Development Block Grant.

Source: American Public Welfare Association, August 1997.

Two additional states (**FLORIDA** and **NORTH CAROLINA**) reported on the Southern Institute site visits that they planned to transfer TANF funds to child care. Since the site visits, both states have made transfers.

Prior to welfare reform, there were several funding categories for child care that provided assistance to welfare families, families transitioning from welfare and going to work and families at risk of going on welfare. Welfare reform combined these categorical child care programs into a block grant and eliminated the federal entitlement. This action basically gave states decision making authority over the administration of child care programs and the opportunity to integrate former categorical programs. To date, only a few southern states have moved to eliminate the categorical approach in favor of a simplified income based system. The major impediment to reforms appears to be insufficient funding.

Unlike Medicaid, child care is not a federal entitlement program. There is no guarantee of access to child care assistance, even if families are eligible under a state's criteria. The number of eligible families who actually receive assistance is determined by the amount of funding made available by each state. Thus, not all income eligible families receive assistance.

Even with the additional allocation of federal child care funding as part of welfare reform, the need remains great. During the site visits, insufficient funding for child care was frequently mentioned as a major issue for states. The combination of insufficiently funded child care programs and the inability of many low income working families to pay the full cost of child care present a looming problem that can and probably will undermine state welfare reform initiatives. All states, even those that are currently able to provide assistance to all families who have applied, expressed concern about the future.

Decisions on the allocation of insufficiently funded child care assistance programs impose difficult choices for public policy makers. The result is often the establishment of policies that produce inequities among different groups of low income families.

These and other issues related to access to child care benefits were discussed at the site visit meetings. Additionally, a survey was administered to collect data on the availability of child care subsidies for welfare related and nonwelfare related families. Survey results, issues and state strategies identified during the site visits are summarized below.

Sufficiency of Child Care Funding

In October 1997, the Southern Institute surveyed the 17 southern states and the District of Columbia on child care. Qualifying groups and sufficiency of child care funding vary considerably across the southern region.

Survey results related to the sufficiency of child care funding are summarized as follows:

- Eight states reported that they were able to provide child care assistance to all groups who would qualify under state eligibility criteria. (**DELAWARE, GEORGIA, LOUISIANA, MARYLAND, MISSOURI, NORTH CAROLINA, OKLAHOMA** and **WEST VIRGINIA**)

- Nine states and the **DISTRICT OF COLUMBIA** reported that they were not currently able to provide child care assistance to all groups who would qualify under state eligibility criteria. (**ALABAMA, ARKANSAS, FLORIDA, KENTUCKY, MISSISSIPPI, SOUTH CAROLINA, TENNESSEE, TEXAS** and **VIRGINIA**)

- Four states reported that child care assistance was not available to working poor families with no connection to welfare. (**ARKANSAS, KENTUCKY, LOUISIANA** and **OKLAHOMA**)

Table 17 on page 57 displays survey results on the sufficiency of child care funding and provides state by state information on qualifying groups.

TABLE 17
SUFFICIENCY OF CHILD CARE FUNDING AND QUALIFYING GROUPS
SOUTHERN REGION, OCTOBER 1997

State	Does Your State Have the Funding to Provide Child Care to All Groups Who Would Qualify Under State Eligibility Criteria?	Qualifying Groups Under State Eligibility Criteria				
		TANF Applicants Searching for a Job	TANF Recipients	Former TANF Recipients Who Left for Earnings	Working Poor Without Welfare Connection	Other
Alabama	No	√	√	√	√	√
Arkansas	No	√	√	√		
Delaware	Yes	√	√	√	√	√
District of Columbia	No		√	√	√	√
Florida	No	√	√	√	√	√
Georgia	Yes	√	√	√	√	
Kentucky	No		√	√		
Louisiana	Yes		√	√		
Maryland	Yes	√	√	√	√	√
Mississippi	No	√	√	√	√	√
Missouri	Yes	√	√	√	√	
North Carolina	Yes	√	√	√	√	√
Oklahoma	Yes	√	√	√		
South Carolina	No	√	√	√	√	
Tennessee	No	√	√	√	√	
Texas	No	√	√	√	√	
Virginia	No	√	√	√	√	
West Virginia	Yes	√	√	√	√	√

Note: TANF is the Temporary Assistance to Needy Families program, which is the cash assistance program that replaced Aid to Families with Dependent Children.

Source: Southern Institute on Children and Families, Southern State Survey on Child Care, October 1997.

Targeting Child Care Assistance to Welfare Related Groups

The federal Transitional Child Care program was eliminated as part of welfare reform. Previous to welfare reform, Transitional Child Care was guaranteed to families leaving welfare for reasons due to earnings. The period of eligibility was set by federal law at no longer than 12 months.

With the passage of welfare reform, states can decide how they want to provide assistance to families leaving welfare for work. Most southern states have retained many elements of the former federal Transitional Child Care program.

A major issue with a transitional child care approach is that it limits child care assistance to an arbitrary time period. Assistance is terminated at the end of a specified time period, whether or not families have increased their earnings enough to afford full payment of child care. A few states mentioned during site visit meetings that efforts are made to continue child care assistance after transitional benefits expire, if the family remains income eligible.

Table 18 provides details on Transitional Child Care in the southern region. It shows that 14 southern states have retained the Transitional Child Care program while three states (**LOUISIANA, MISSOURI** and **NORTH CAROLINA**) and the **DISTRICT OF COLUMBIA** have eliminated it. Of the 14 states which have retained a Transitional Child Care program, eight states limit assistance to 12 months and six states provide assistance beyond 12 months.

TABLE 18 TRANSITIONAL CHILD CARE			
State	Does Your State Have a Transitional Child Care Program?	What Is the Time Period for Transitional Child Care (in Months)	Must Cash Assistance Be Received in 3 of Previous 6 Months for Eligibility?
Alabama	Yes	12	No
Arkansas	Yes	36	No
Delaware	Yes	24	No
District of Columbia	No		
Florida	Yes	24	Yes
Georgia	Yes	12	No
Kentucky	Yes	12	No
Louisiana	No		No
Maryland	Yes	12	Yes
Mississippi	Yes	12	No
Missouri	No		No
North Carolina	No		No
Oklahoma	Yes	12	No
South Carolina	Yes	24	No*
Tennessee	Yes	18	No
Texas	Yes	12 to 18	Yes
Virginia	Yes	12	No
West Virginia	Yes	12	Yes

*South Carolina requires that cash assistance be received in only the previous month.

Source: Southern Institute on Children and Families, Southern State Survey on Child Care, October 1997.

As shown in Table 18, 13 southern states (**ALABAMA, ARKANSAS, DELAWARE, GEORGIA, KENTUCKY, LOUISIANA, MISSISSIPPI, MISSOURI, NORTH CAROLINA, OKLAHOMA, SOUTH CAROLINA, TENNESSEE** and **VIRGINIA**) have eliminated the previous federal requirement that families must be on welfare for three out of the previous six months in order to qualify for Transitional Child Care. **SOUTH CAROLINA**

eliminated the rule and replaced it with a requirement that a family be on welfare the previous month to qualify for Transitional Child Care. Other states indicated that they were considering elimination of this rule. Eliminating the three out of six month rule removes the incentive to be on welfare for a short period of time in order to gain access to child care assistance.

Asset Testing

As discussed in the child health coverage chapter, testing for assets impedes access to benefits for low income working families who are eligible under a state's income criteria. Most southern states and the District of Columbia have eliminated any form of asset testing in order for families to qualify for child care assistance. **ARKANSAS** is the only southern state to require an asset test for all families applying for child care assistance. **TENNESSEE** requires an asset test for welfare eligibility, but not for nonwelfare related child care.

Child Care Eligibility Process

Separate eligibility categories that are based on criteria in addition to income complicate the eligibility process for families seeking assistance and for administering agencies. From an eligibility standpoint, an income based system is less complicated and more efficient. The dilemma for states is that while eligibility simplification will reduce the complexity of the eligibility process and save administrative dollars, it makes child care benefits accessible to more families and thus would increase expenditures.

Child care eligibility process issues and strategies are discussed below and survey results are presented.

Eligibility Determination and Redetermination

One strategy for improving access for working families is to allow families to apply by mail or telephone without requiring a face-to-face interview. Another strategy for making benefits more accessible is to have a 12 month period of eligibility between redeterminations.

States were surveyed on the process for determining and redetermining eligibility for child care assistance. Survey results are as follows:

- Seven states (**LOUISIANA, MARYLAND, MISSOURI, NORTH CAROLINA, SOUTH CAROLINA, TEXAS** and **VIRGINIA**) do not require face-to-face interviews for families applying for child care assistance.

- Eight states (**GEORGIA, KENTUCKY, MARYLAND, MISSOURI, NORTH CAROLINA, OKLAHOMA, SOUTH CAROLINA** and **VIRGINIA**) require families to have their eligibility for child care redetermined every 12 months.

- Nine states (**ALABAMA, ARKANSAS, DELAWARE, FLORIDA, LOUISIANA, MISSISSIPPI, TENNESSEE, TEXAS** and **WEST VIRGINIA**) and the **DISTRICT OF COLUMBIA** require families to have their eligibility for child care redetermined every six months.

- Four states (**ALABAMA, GEORGIA, KENTUCKY** and **TENNESSEE**) and the **DISTRICT OF COLUMBIA** require families to have face-to-face interviews at redetermination.

Table 19 provides specific information on determination and redetermination policies by state.

TABLE 19
ELIGIBILITY DETERMINATION AND REDETERMINATION POLICIES FOR CHILD CARE

State	Months Between Eligibility Redeterminations	Are Face-to-Face Interviews Required at Initial Determination?	Are Face-to-Face Interviews Required at Redetermination?
Alabama	6	Yes (Usually)	Yes (Usually)
Arkansas	6	Yes	No
Delaware	6	Yes	No
District of Columbia	6	Yes	Yes
Florida	6	Varies by District	No
Georgia	12	Yes	Yes
Kentucky	12	Yes	Yes
Louisiana	6	No	No
Maryland	12	No	No
Mississippi	6	Yes	No
Missouri	12	No	No
North Carolina	12	No	No
Oklahoma	12	Yes	No
South Carolina	12*	No	No
Tennessee	6	Yes	Yes
Texas	6	No	No
Virginia	12	No	No
West Virginia	6	Yes	No

*In South Carolina, the duration of eligibility between redeterminations varies by funding sources and can be less than 12 months.

Source: Southern Institute on Children and Families, Southern State Survey on Child Care, October 1997.

Verification Requirements

As mentioned in Chapter 3, verification requirements can present eligibility barriers for families seeking health care coverage for their children. The same is true for families seeking assistance with child care. Identifying areas where more discretion can be used by staff making eligibility determinations can result in improving access to child care assistance.

Table 20 displays the varying eligibility verification policies for income and age across the southern region. The table shows that in most states, eligibility workers never have discretion to allow a family to declare income. Allowing eligibility worker discretion in circumstances where a third party, e.g., an employer, is uncooperative in providing verification may remove a barrier for an income eligible family. Seeking verification through employment system records may provide another avenue for obtaining acceptable verification.

With regard to allowing self declaration for the age of children, 11 states allow eligibility worker discretion (**ARKANSAS**, **FLORIDA**, **GEORGIA**, **LOUISIANA**, **MARYLAND**, **NORTH CAROLINA**, **OKLAHOMA**, **SOUTH CAROLINA**, **TEXAS**, **VIRGINIA** and **WEST VIRGINIA**).

TABLE 20 VERIFICATION POLICIES ON INCOME AND AGE		
State	Can Income Be Declared?	Can Age Be Declared?
Alabama	Never	Never
Arkansas	Never	Always
Delaware	Never	Never
District of Columbia	Sometimes	Never
Florida	Never	Sometimes
Georgia	Never	Always
Kentucky	Never	Never
Louisiana	Never	Always
Maryland	Never	Always
Mississippi	Sometimes	Never
Missouri	Never	Never
North Carolina	Never	Always
Oklahoma	Sometimes	Always
South Carolina	Never	Always
Tennessee	Never	Never
Texas	Never	Always
Virginia	Never	Sometimes
West Virginia	Never	Always
Source: Southern Institute on Children and Families, Southern State Survey on Child Care, October 1997.		

Continuity of Eligibility

States were also asked to provide information on what happens when a family becomes ineligible for a particular child care program. Some states take the initiative to search for other eligibility categories to avoid the loss of child care assistance while others rely upon the family to apply for another category of assistance. The survey findings are summarized as follows:

- Seven states (**ALABAMA, FLORIDA, GEORGIA, MARYLAND, MISSOURI, TEXAS** and **VIRGINIA**) automatically conduct an agency search for another eligibility category when a family becomes ineligible for a particular eligibility category rather than requiring the family to reapply.

- Six states (**ARKANSAS, LOUISIANA, MISSISSIPPI, OKLAHOMA, SOUTH CAROLINA** and **TENNESSEE**) and the **DISTRICT OF COLUMBIA** require families to reapply when they become ineligible for a particular eligibility category.

- Four states (**DELAWARE, KENTUCKY, NORTH CAROLINA** and **WEST VIRGINIA**) reported that child care funding sources are integrated, therefore multiple eligibility determinations are unnecessary.

Table 21 provides specific information on policies regarding category changes by state.

TABLE 21 WHAT HAPPENS WHEN A FAMILY BECOMES INELIGIBLE FOR A PARTICULAR CHILD CARE PROGRAM?			
State	Agency Automatically Searches for Another Category	Family Required to Reapply	Other
Alabama	Yes		
Arkansas		Yes	
Delaware			Seamless system eliminates categories of eligibility
District of Columbia		Yes	
Florida	Yes		
Georgia	Yes		
Kentucky			All child care programs within the Cabinet are combined. Assist with search outside of the Cabinet.
Louisiana		Yes	
Maryland	Yes		
Mississippi		Yes	
Missouri	Yes		
North Carolina			Funding sources are blended so that families do not have to reapply to move from one category to another.
Oklahoma		Yes	
South Carolina		Yes	
Tennessee		Yes	
Texas	Yes		
Virginia	Yes		
West Virginia			Seamless system. Families may mail in review at time of closure of AFDC benefits to determine continuing eligibility
Source: Southern Institute on Children and Families, Southern State Survey on Child Care, October 1997.			

Information Outreach

As reported in Chapter 2, research by the Southern Institute found that many welfare recipients and transitional Medicaid recipients did not understand how benefits are affected when a parent moves from welfare to work. Information outreach to inform families about the availability of subsidies is essential to improving access to child care assistance. Strategies to accomplish child care outreach are discussed in the Information Outreach chapter.

Information outreach targeted to welfare families is especially important. In one Southern Institute study, personal interviews with welfare recipients and transitional Medicaid recipients were conducted to gain insight on how to reduce welfare dependency.[17] During the interviews, recipients were asked to choose the benefit they considered most important to their ability to accept a full time job. The five choices were: (1) Medicaid for myself; (2) Medicaid for my children; (3) Child care; (4) Food Stamps; or (5) Transportation. As shown in Table 22, almost half of the recipients stated that child care was the benefit they needed most to be able to work full time.

TABLE 22
DISTRIBUTION OF STUDY RECIPIENTS ON THE BENEFIT CONSIDERED MOST IMPORTANT TO ACCEPT A FULL TIME JOB

Most Important Benefit	Percentage of Recipients
Child Care	48%
Medicaid For Children	32%
Transportation	12%
Food Stamps	6%
Medicaid For Myself	3%
TOTAL	100%

Source: Southern Institute on Children and Families, 1994. Data collected from recipient interviews in Charlotte, North Carolina and Nashville, Tennessee.

[17] Shuptrine, Relationship of Health Coverage.

State Collaboration With Head Start

Some states expressed concerns regarding their lack of success in establishing statewide collaborative arrangements with Head Start providers. Issues mentioned included the need for full day/full year child care, the need for services for younger children, parent financial participation, payer of last resort policies and differing audit requirements.

Several states mentioned that governance is an issue in achieving collaboration. Head Start remains a federal program and there appears to be no incentive for Head Start agencies to collaborate with states on child care. While states appeared willing to work collaboratively on issues and several reported some local successes, several expressed frustration with coordination efforts.

The survey asked states to provide information on collaboration strategies with Head Start. Appendix F provides contact information for state programs that reported some progress in achieving collaboration

State Strategies To Improve Access to Child Care Assistance

Several state strategies that improved access to child care assistance are presented below and contact information is provided.

North Carolina

An initiative of Governor James B. Hunt, the Smart Start program has increased the availability of child care and quality of care in North Carolina. Smart Start is a comprehensive early care and education program with the goal of preparing children to succeed in school.

Through strong leadership and advocacy, the child care income eligibility level has been raised to serve families up to 214% of the poverty level, regardless of whether or not they have a connection to welfare. All parent fees are based on a sliding fee scale depending upon the family's income.

Approximately $6 million in TANF dollars has been transferred into child care. A request to move an additional $10 million has been made to the state legislature.

Contact: Stephanie Fanjul
Division of Child Development
Department of Human Resources
101 Blair Drive
Raleigh, NC 27603
919-662-4543

Missouri

The Missouri child care program provides low income families assistance with child care costs in one of two ways; 1) reimbursement to parents, or 2) direct payment to eligible child care providers. Families whose income falls at or below approximately 133% of poverty are eligible for services on a sliding fee basis. Families with income below approximately 60% of poverty or with special needs children do not pay a sliding fee.

Child care assistance is provided to low income families to allow parents to work or to attend school or job training programs.

Contact: Tom Jones
Department of Social Services
221 W. High Street
Jefferson City, MO 65101
573-526-3581
tjones@mail.state.mo.us

Florida

All state and federal funding is placed in the budget of one agency. Therefore, families are able to access child care for a number of eligibility categories at one location and can move from one category to another without disruption of eligibility.

All families using subsidized child care pay a fee in order to stretch funds to serve additional families.

Child care funding has been increased by moving $150 million in excess TANF dollars to child care. The movement of these funds ensures that all welfare clients needing child care to participate in work activities receive care.

An interdepartmental agreement between the Department of Labor, Jobs and Benefits program and the Department of Children and Families (Economic Self Sufficiency and Child Care) was established. This agreement improves access to child care by clearly identifying each step of the welfare process, child care eligibility requirements, when services are applicable and who is responsible for completing the authorization and referral.

A child care partnership matching grant program was established in which the legislature appropriated $6 million and local business agencies matched that amount to provide child care services to the working poor.

Florida created the state Work and Gain Economic Self Sufficient (WAGES) Board to oversee welfare. The WAGES Board is composed of public and private representatives, including business, and has provided leadership in improving access to child care in Florida.

Contact: Larry Pintacuda
Florida Department of Children and Families
1317 Winewood Boulevard
Building 7, Room 228
Tallahassee, FL 32399-0700
850-488-4900

Actions That Can Improve Access to Child Care

There are a number of actions that can be taken to improve access to child care assistance for low income families. Some of these actions are described below.

1) To assist more low income families with the high cost of child care and to discourage welfare as an entry point for child care assistance, states should identify and implement actions to achieve an income based system of child care subsidies for low income working families with no requirement that a family be on welfare for any period of time in order to obtain assistance in paying for child care.

2) To avoid denying child care assistance to children in income eligible families who have resources that exceed state asset limits, states should exempt assets when determining eligibility for child care assistance.

3) To assure that the application and recertification process is not burdensome for low income families seeking child care assistance, states should review eligibility policies and procedures, including recertification periods and verification requirements.

4) In order to provide continuity of child care assistance, states should review policies regarding agency initiative in making category changes for low income families whose children remain eligible.

5) To assure that families know about available child care assistance, states and communities should design and implement outreach strategies to communicate the availability of child care assistance for low income working families.

6) To foster cooperation with Head Start, states should identify and disseminate information on successful Head Start collaboration strategies and document issues that need to be addressed at the federal level.

CHAPTER 5
TRANSPORTATION

The barriers that families without personal automobiles confront every day, especially if they live in rural areas or outside of city bus routes, are mind boggling. Because public and human services transportation systems in most states are inadequate, these families are often forced to rely on relatives, friends, or co-workers for rides. If they are able to find transportation at all, the time involved in getting to and from work, to and from health care services, to and from child care centers and to and from agencies that require face-to-face application interviews results in a substantial drain of time and energy.

Transportation consistently shows up as a barrier to accessing health care and other services, especially in rural areas. It also has been identified as a major impediment to gaining and sustaining employment for families on welfare. And it is cited in community and state human services needs assessments on a regular basis. Despite its prominence as a recognized problem, comprehensive solutions have been elusive.

It appears that much of the problem can be resolved with effective leadership and collaboration among public and private agencies currently delivering transportation services. Without such leadership initiatives, however, it is likely to remain a problem that continues to be passed around with no one entity accepting ownership to resolve it.

Transportation Strategies

On the state site visits, it was clear that the various agencies represented at the meetings had been struggling with transportation issues and were very attuned to the linkage between effective transportation and achievement of the goals of their health and human service programs. The general mood at the site visit meetings when the subject of transportation was broached was that the need was great and that solutions had not been found. Few examples of

coordinated transportation approaches and innovative strategies were identified during the site visit meetings.

Transportation strategies mentioned by states included small scale private sector initiatives to provide donated cars to families and donated surplus government vehicles to families leaving welfare for work. Some states also mentioned attempts to work out arrangements with churches and schools to use vans and buses, but such attempts for the most part had been unsuccessful.

NORTH CAROLINA reported that under the leadership of Governor James B. Hunt, a Transit 2001 Commission was established to study the public transportation system in North Carolina and to make recommendations on how to improve the system.

GEORGIA reported that a Medicaid transportation broker system had been established in five regions of the state. The system is available to other agencies if a funding source is provided. The Georgia Department of Medical Assistance worked with state transportation officials to ensure that the brokers work with other organizations to see that services are not duplicated.

It was reported that some banks in **MISSOURI** offer individuals low interest loans to purchase a vehicle. The banks also make efforts to refer individuals to reliable dealers and mechanics. A federal law called the Community Reinvestment Act requires banks to dedicate a certain percentage of deposits to community needs and this is one strategy that was being utilized.

Two transportation initiatives mentioned on the site visits are presented below and contact information is provided.

Kentucky

Initiated by Governor Paul Patton, an Empower Kentucky Transportation Delivery Team with representatives from the Cabinet for Health Services, Cabinet for Families and Children, Workforce Development Cabinet, and the Transportation Cabinet was formed in January 1997. The mission of Empower Kentucky is to formulate new business procedures, policies, and technical provisions necessary for a statewide coordinated human service transportation delivery service network to implement the process.

The transportation delivery process includes the consolidation of the administration and funding for all human service transportation requirements under one agency. The Transportation Cabinet was selected to be the responsible agency to administer the program. The programs involved in the coordinated system include, but are not limited to: non-emergency medical, Aging, Job Training Partnership Act (JTPA), Temporary Assistance to Needy Families (TANF), Vocational Rehabilitation, Department of Blind and the general public.

Transportation will be provided through a system of transportation brokers/providers. There are sixteen human service transportation regions and a broker/provider will be selected for each area through the competitive bid process and will be responsible for coordinating and providing all required trips. Funding for the program will be based on a capitated rate determined for each transportation region. The Transportation Cabinet will contract for service, make all payments to providers, monitor service delivery, provide all required reporting, and establish a complaint tracking and monitoring system for recipients of all programs.

A Medicaid waiver for freedom of choice has been submitted to HCFA so that the most appropriate type of transportation for the trip can be provided.

In April 1998, three demonstration regions should be in operation with the entire state network expected to be operational by the end of 1998.

Contact: Jerry Ross
Kentucky Transportation Cabinet
125 Holmes Street, 3rd Floor
Frankfort, KY 40622
502/564-7433

Charity Cars

Charity Cars, Inc. is a nonprofit program that provides vehicles to economically disadvantaged individuals to enable them to locate meaningful employment. The program provides participants with a vehicle which has been refurbished and the initial tag cost and down payment for insurance if necessary. Mechanical upkeep and towing services are also provided for a six month period. The individual is asked to pay for the cost of operating the car after six months.

Referrals for the program are accepted from a broad range of public and private service organizations. Government agencies participate in the screening process and in the delivery of support services related to transportation. Individuals and businesses donate the vehicles. Businesses also contribute automobile parts, oil and tires. Mechanics volunteer their repair services. Employment agencies offer intense placement services to help Charity Cars participants find employment.

Charity Cars has developed replication materials. The Charity Cars organizational structure for replication is similar to that of Habitat for Humanity. Affiliates will adhere to a flexible yet structured program with checks and balances to ensure quality control.

Contact: Brian Menzies
Charity Cars, Inc.
1980 North Cameron Avenue
Sanford, FL 32771
407/324-5050

During follow-up work subsequent to the site visits, a national information and technical assistance resource was identified. The U.S. Department of Health and Human Services Community Transportation Assistance Project (CTAP) provides information and answers to questions about transportation issues, such as accessibility, coordination, funding opportunities, training, management, legislation and regulations. CTAP has an information clearinghouse called the National Transit Resource Center. The transit hotline is (800)527-8279. Information on the electronic bulletin board is available by calling (202)628-2537.

Transportation experts indicate that there are no statutory provisions prohibiting coordination of human services transportation. Coordination has been shown to be cost effective with savings of 10% to 20% being generally achievable and some programs reaching 30% to 35% savings. In a federal/state demonstration project, it has been found that transportation approaches based on volunteer networks did not work well and that group transportation delivery strategies worked better than trying unusual approaches.[18]

[18] Robert T. Goble, lecture presented at the Southern Regional Forum on Improving Access to Benefits for Families with Children, Charleston, SC, 12 December 1997.

Asset Testing

There is one policy area where it is clear what *not* to do. Transportation is an area where asset limits have proven to be poor public policy. For many years, federal welfare rules did not allow a family to own a car worth more than $1,500 equity value. There were no exceptions for work or job training activities as was allowed under food stamp resource limits. Such strict resource limits required families to be impoverished in order to obtain and retain welfare assistance. Thus, it is reported that today only 6% of welfare families own cars.[19] This represents a major barrier to these families reaching self sufficiency.

With the new flexibility that states now have under TANF, many states have taken action to remove an automobile asset test altogether or have raised the value limit.

Actions Needed to Help Families Overcome Transportation Barriers

Public policy attention to help families overcome transportation barriers is a critical need. Some actions that can lead to improvements are described below.

1) To develop more efficient and responsive transportation solutions for poor and low income citizens, states should create state level or multi-state work groups composed of the various public and private agencies that purchase or provide transportation services. The objectives would be to:

   - Identify strategies to effectively and efficiently coordinate transportation services designed to assist low income citizens; and
   - To identify strategies to help low income families acquire personal automobiles.

   Including advocacy groups and/or family representatives in the deliberations will provide needed input from user groups. The experience of local initiatives should be examined and information on state or federal demonstration projects should be reviewed. Federal technical assistance should be provided to avoid misinterpretation of federal policies and rules and to identify coordination and collaboration opportunities.

2) To avoid penalizing low income families who own an automobile, states should eliminate automobile asset testing for families applying for child health coverage, child care assistance and other benefits.

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[19] Ibid.

CHAPTER 6
EARNED INCOME TAX CREDIT

The Earned Income Tax Credit (EITC) is administered by the Internal Revenue Service and was established to supplement the incomes of families making low wages. The EITC can provide substantial assistance to poor and low income working families. In 1997, a family with one child can earn up to $25,760 and receive the EITC and families with two or more children can earn up to $29,290 and receive the EITC. The amount of EITC assistance received by families is based on a sliding scale. In 1997, a one-child family earning at the minimum wage can receive $2,210 in EITC cash and a two-child family earning the minimum wage can receive $3,656.

There are two ways a family can get the cash provided through the EITC. They can receive it at the end of the year when they file their tax return or they can get part of the EITC in advance with each paycheck and the rest when they file their tax return. A family must file a federal tax return to receive the EITC.

The EITC cash can help families pay for health coverage, child care, transportation or other needs. Getting the word out about the EITC should be a major goal for public and private organizations attempting to assist low income working families.

Outreach

Focus groups conducted by the Southern Institute in nine counties in **GEORGIA** and **NORTH CAROLINA** indicated the need for welfare agencies to educate families about the availability of the EITC. In **GEORGIA**, 41% of the EITC questions asked on the pretest were answered incorrectly by welfare and Transitional Medicaid families who participated in the focus groups. In **NORTH CAROLINA**, 38% of the EITC questions asked on the pretest were answered incorrectly.[20] (See Chapter 2 for a discussion of post test results.)

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[20]Sarah C. Shuptrine and Genny G. McKenzie, Information Outreach to Reduce Welfare Dependency: A Georgia Welfare Reform Initiative, Phase 1 Report, prepared for the Georgia

Additionally, in both **GEORGIA** and **NORTH CAROLINA**, caseworkers were not well informed on the EITC. The results of the site visits during the current southern regional project indicated that the experience in Georgia and North Carolina was not unusual. States expressed a desire to learn more about the EITC and to share information about it with families.

The information outreach brochures developed by the Southern Institute provide states with a tool to educate both caseworkers and families about the cash available through the EITC. The brochures specifically state that caseworkers have copies of the Form W-5, which is the EITC advance payment form to be filed with employers. This means that the agency must have ample copies of the form and caseworkers must be informed about the EITC. A caseworker in **NORTH CAROLINA** reported that the information in the brochure "forced us to really start promoting the EITC."

Two states (**MARYLAND** and **OKLAHOMA**) and the **DISTRICT OF COLUMBIA** reported that they had worked with the Center for Budget and Policy Priorities to develop strategies to promote the EITC.

Project Get Together in **OKLAHOMA** is an example of an EITC outreach program. It is briefly described below.

Oklahoma

Project Get Together is a Tulsa anti-poverty agency which offers a program to educate and help low income families claim the EITC. The program receives funding from the Charles and Lynn Schusterman Family Foundation. *Project Get Together* receives strong support from Governor Frank Keating, including a special mailing to 37,000 employers with a personal letter. The project produces radio and TV public service announcements and works with the print media to promote the EITC. There is a toll free number operating during the tax season staffed by operators rather than answering machines. The project links with IRS Volunteer Income Tax Assistance (VITA) sites to provide assistance with tax preparation and electronic filing services at no cost.

Department of Human Resources, Division of Family and Children Services (Columbia, SC: Southern Institute on Children and Families, August 1996) p. 7; and Sarah C. Shuptrine and Genny G. McKenzie, Information Outreach to Reduce Welfare Dependency: A North Carolina Welfare Reform Initiative, Final Report (Columbia, SC: Southern Institute on Children and Families, May 1996) p. 8.

Contact: Steven Dow
Project Get Together
2020 S. Maplewood Street
Tulsa, OK 74112
918/835-2882

Asset Testing

The eligibility rules related to how the EITC cash is counted are inconsistent and confusing to families applying for health and other benefits.

With regard to income, federal law prohibits counting the EITC as income for purposes of calculating eligibility or benefit amounts for Medicaid, Supplemental Security Income (SSI), food stamps or housing. Each state determines whether or not to count the EITC as income when calculating TANF cash assistance benefits. No southern state reported that the EITC was counted as income for TANF benefits.

With regard to assets, if a state imposes a Medicaid assets test for children, federal law allows the EITC to be counted. Only two southern states (**ARKANSAS** and **TEXAS**) count assets in determining Medicaid eligibility for children. However, **ARKANSAS** specifically excludes the EITC as an asset in determining Medicaid eligibility for children. **TEXAS** counts the EITC as an asset for children using the food stamp policy for EITC lump sum payments.

Counting the EITC as an asset impedes children's access to Medicaid and can also result in eligible children losing Medicaid coverage. Additionally, counting the EITC against families whose children would otherwise be eligible for Medicaid conflicts with state and federal policies which promote work.

Actions Needed to Improve Access to EITC and Actions Needed to Remove EITC Barriers to Medicaid Eligibility

Actions that can be taken to improve access to the EITC and to assure that EITC rules do not present barriers to Medicaid eligibility for children are outlined below:

1) To assure that families learn about the EITC, states should conduct information outreach campaigns, with special efforts targeted to families on welfare, and provide EITC information and forms to eligibility workers.

2) To assure that children do not lose Medicaid because their family claimed the EITC and did not spend their refund quickly, states should exclude the cash received through the EITC, whether through the advance method or end of year tax refund, from the state definition of assets.

3) To avoid children losing Medicaid coverage, the federal government can enact the same policy it has for income and thus disallow the counting of EITC cash as an asset in determining Medicaid eligibility.

CHAPTER 7
FEDERAL DEVELOPMENTS

Almost all of the Southern Institute site visits had been completed prior to the signing of the Balanced Budget Act of 1997 in August 1997. The Act includes several new opportunities for states as they strive to make health coverage opportunities available to more low income children. Some of the provisions are listed below.

- A new State Children's Health Insurance Program (CHIP) was created under Title XXI of the Social Security Act. States may initiate and expand health coverage for low income, uninsured children using an enhanced federal match. States can provide coverage for children through a separate child health insurance program, through the Medicaid program, or through a combination of these programs. States can spend up to 10% of their total CHIP expenditures (federal and state) on administration, outreach and direct purchase of health services.

- State CHIP plans are required to include a description of the procedures to be used to inform families of children eligible for child health assistance of the availability of such assistance and to assist in enrolling children. States are also required to provide an annual report to the HHS Secretary on the progress made in reducing the number of uncovered low-income children during the prior fiscal year.

- States now have the option to provide a full continuous 12 months of eligibility for children enrolled in Medicaid or CHIP.

- States can now provide for a Medicaid presumptive eligibility period for children. The period would begin when a "qualified entity" determines, based on preliminary information, that the family's income is below the state Medicaid eligibility level. Qualified entities are providers of health care items and services under the State Medicaid Plan and entities that determine eligibility for Head Start, Special Supplemental Food Program for Women, Infants and Children (WIC) and child care subsidies under the Child Care and Development Block Grant (CCDBG). Families have until the end of the following month to submit a full Medicaid application. If the family does not complete the necessary requirements for formal determination, the child's Medicaid eligibility will expire.

In recent weeks, there have been further federal developments that deal with the issues discussed in this report. Some of these developments are listed below.

- The following proposals are included in the Administration's budget released on February 2, 1998: 1) $7.5 billion additional federal funding for the CCDBG over a five year period to double the number of children who can receive child care subsidies; 2) an increase in the child care tax credit; 3) a new tax credit for businesses that offer child care for their employees; 4) additional funding for Head Start; 5) additional funding for school-community partnerships to establish or expand after school care; and, 6) several measures designed to improve child care safety and quality.

- On January 23, 1998, the Health Care Financing Administration (HCFA) sent a letter to state health officials summarizing "new and existing opportunities for outreach to uninsured children." The letter provides specific information about and interpretation of CHIP and existing Medicaid provisions, as well as information on proposed legislation. The topics covered are: 1) funding for outreach, including details on federal matching under Medicaid and CHIP; 2) expanding sites for enrolling children; 3) simplifying enrollment; and, 4) other outreach strategies. The letter is available at hcfa.gov/init/children.htm.

GLOSSARY

Assets

Determined by federal and state statutes and regulations, asset limitations govern the maximum amount of assets a person can own and still qualify for benefits. When asset tests are used in the eligibility process, states typically test for liquid assets and vehicles.

Federal Poverty Level

Each year the United States Department of Health and Health Services updates and publishes the federal poverty income guidelines that are used in determining eligibility for specific Medicaid programs and other benefit programs. The federal poverty level varies by family size. In 1997, the federal poverty level for a family of three was $13,330 annual income.

Medicaid

Medicaid is a jointly-funded, federal-state health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled.

Poverty Related Children

Medicaid has an eligibility category for children which is based on a percentage of the federal poverty level. This report refers to this category as poverty related children or poverty related Medicaid for children.

State Children's Health Insurance Program

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (CHIP). The purpose of the program is to provide states with federal funding on a federal-state matching basis to provide more low income, uninsured children with health coverage through expansions and outreach. States can choose to expand coverage through Medicaid, create a separate health coverage program or implement a combined strategy.

Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) Program became effective July 1, 1997, and replaced what was then commonly known as welfare, or Aid to Families with Dependent Children (AFDC) and the Job Opportunities and Basic Skills Training (JOBS) programs. TANF provides assistance and work opportunities to needy families by granting states the federal funds and wide flexibility to develop and implement their own welfare programs. Each state sets its own eligibility levels. TANF recipients are not automatically provided Medicaid coverage as they were with AFDC.

APPENDIX A

STATE CONTACTS FOR SOUTHERN INSTITUTE SITE VISITS

State Contacts for Southern Institute Site Visits
March – September 1997

Alabama

Joel Sanders
Director
Welfare Reform Division
Department of Human Resources
Urban County Government Center
50 Ripley Street
Montgomery, AL 36130
334/242-1310

Assisted by: Jean Blackmon

Arkansas

Joe Quinn
Communications Director
Department of Human Services
PO Box 1437
Little Rock, AR 72203-1437
501/682-8650

Delaware

Elaine Archangelo
Director
Delaware Division of Social Services
1901 N. DuPont Highway
New Castle, DE 19720
302/577-4402

Assisted by: Jack Holloway

District of Columbia

Annie Goodson
Commissioner
Commission on Social Services
609 H Street, NE – 5th Floor
Washington, DC 20002
202/727-5930

Paul Offner
Commissioner
Health Care Finance Commission
2100 Martin L. King Avenue, SE
Washington DC 20020
202/727-0735

Commander Jim Thompson
Acting Director
Mayor's Office of Health Policy
441 4th Street, NW, Suite 1002
Washington, DC 20001
202/727-9239

Florida

Don Winstead
Director of Welfare Reform
Department of Children and Families
1317 Winewood Boulevard
Building 3, Room 400
Tallahassee, FL 32399-0700
850/921-5567

Assisted by: Catherine Smith

Georgia

Janet Bittner
Executive Director
Georgia Policy Council for
Children and Families
47 Trinity Street, Suite 501-H
Atlanta, GA 30334
404/657-0630

Assisted by: Annaka Woodruff

Kentucky

Sharon Perry
Welfare Reform Staff Assistant
Cabinet for Families and Children
275 E. Main Street
3rd Floor Center
Frankfort, KY 40621
502/564-3106

Assisted by: Donna Britton

Louisiana

Madlyn Bagneris
Secretary
Department of Social Services
PO Box 3776
Baton Rouge, LA 70821
504/342-0286

Assisted by: Beverly Tircuit

Maryland

Alvin Collins
Secretary
Department of Human Resources
311 W. Saratoga Street
Baltimore, MD 21201-3521
410/767-7486

Assisted by: Lynda Fox/Edith Saunders

Mississippi

Anna Marie Barnes
Health and Human Services Advisor
Office of the Governor
PO Box 139
Jackson, MS 39205
601/359-3150

Assisted by: Larry Temple/Kathy McKnight

Missouri

Gary Stangler
Director
Department of Social Services
PO Box 1527
Jefferson City, MO 65102
573-751-4815

Assisted by: Doris Lorts

North Carolina

C. Robin Britt
Policy Advisor for Children,
Families and Non-Profits
Office of the Governor
State Capitol Building
Raleigh, NC 27601-2905
919/715-9611

Assisted by: Faye Stone

Oklahoma

George Miller
Director
Department of Human Services
PO Box 25352
Oklahoma City, OK 73125
405/521-4415

Assisted by: Mary Stalnaker/Sandy Headrick

South Carolina

Lisa Eskew
Coordinator for South Carolina Works
Office of the Governor
PO Box 11369
Columbia, SC 29211
803/734-9818

Tennessee

Wanda Moore
Director
Employment & Training Services
Department of Human Services
400 Deaderick Street
Nashville, TN 37248
615/313-7099

Texas

Jim Underwood
HHS Policy Assistant
Governor's Policy Office
PO Box 12428
Austin, TX 78711
512/463-1774

Assisted by: Jorey Berry

Virginia

Scott Oostdyk
Deputy Secretary
Department of Health
and Human Resources
202 N. 9th Street, Suite 622
Richmond, VA 23219
804/786-7765

Assisted by: Joyce Crute/Marcy Nobles

West Virginia

Joan E. Ohl
Secretary
Department of Health and
Human Resources
State Capitol Complex
Building 3, Room 206
1900 Kanawha Boulevard East
Charleston, WV 25305
304/558-0684

Assisted by: Ann Garcelon

APPENDIX B

SOUTHERN REGIONAL FORUM ON IMPROVING ACCESS TO BENEFITS FOR FAMILIES WITH CHILDREN

Southern Regional Forum on Improving Access to Benefits for Families With Children

December 12, 1997
Charleston, South Carolina

Sponsored by
The Robert Wood Johnson Foundation

Conducted by
Southern Institute on Children and Families

PROGRAM

7:00-8:00 ***Registration and Continental Breakfast***

8:00-8:30 ***Opening Remarks***
Mayor Unita Blackwell, Board Chairman
Southern Institute on Children and Families

Forum Overview and Report on Site Visits
Sarah Shuptrine, President
Southern Institute on Children and Families

8:30-9:30 **Supporting Work Through Child Care Subsidies**

Moderator: Barbara Kamara, Executive Director
Office of Early Childhood Development
DC Department of Human Services

- Stephanie Fanjul, North Carolina Division of Child Development
- Tom Jones, Missouri Department of Social Services
- James Cosper, Florida Office of Child Care Services
- Steven Golightly, Administration for Children and Families Region IV

Audience Questions

9:30-9:45 ***Break***

9:45-11:15 ***Making Health Coverage Available to Working Families***

Moderator: Pam Leyhe, Deputy Director
Missouri Department of Social Services

- William Freeburn, Arkansas Department of Human Services
- Jana Leigh Key, Healthy Kids Replication Program
- Cornelia Gibbons, Office of the Governor, South Carolina
- Keith Johnson, Tennessee Bureau of TennCare
- Deborah Giffin, Virginia Department of Medical Assistance
- Richard Fenton, Health Care Financing Administration

Audience Questions

11:15-12:15 ***Implementing State and Community Outreach***

Moderator: Alvin Collins, Secretary
Maryland Department of Human Resources

- Rebecca W. Shoaf, Georgia Right From the Start Medicaid
- Keith Johnson, Tennessee Bureau of TennCare
- Jack Frazier, West Virginia Department of Health and Human Resources
- William Freeburn, Arkansas Department of Human Services

Audience Questions

12:15-1:15 ***Lunch at Historic Hibernian Hall***

Introductions
Chief Reuben Greenberg, Member, Board of Directors
Southern Institute on Children and Families

Remarks by Charleston Mayor Joseph P. Riley, Jr.

Remarks by Judith Whang
Program Officer
The Robert Wood Johnson Foundation

1:30-2:30 ***Removing Health Coverage Eligibility Barriers***

Moderator: Margaret Dunkle, Director, IEL Policy Exchange
Institute for Educational Leadership

- Susan Woodbury, Delaware Health and Social Services
- Peggy Peters, Georgia Division of Family and Children Services
- Gwen Power, South Carolina Department of Health and Human Services
- Deborah Giffin, Virginia Department of Medical Assistance
- Roger Neptune, West Virginia Department of Health and Human Resources

Audience Questions

2:30-3:20 ***Reaching for Transportation Solutions***

Moderator: Lee Alexander, Executive Director
National Transportation Consortium of States

- Robert Goble, Carter Goble Associates, Inc.
- Jerry Ross, Kentucky Division of Multimodal Programs
- Brian Menzies, Charity Cars, Inc.

Audience Questions

3:20-3:30 ***Summary of Follow Up Actions***

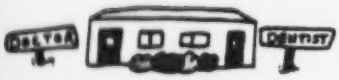
Sarah Shuptrine

3:30 ***Adjourn***

APPENDIX C
GEORGIA OUTREACH BROCHURES

GEORGIA VERSION

HAVE YOU HEARD ABOUT BENEFITS FOR WORKING FAMILIES???



MEDICAID COVERAGE FOR CHILDREN

CHILD CARE ASSISTANCE

EARNED INCOME TAX CREDIT

FOOD STAMPS

FREE HELP WITH FILING TAX RETURN

ASSISTANCE WITH CHILD SUPPORT

READ ON TO LEARN ABOUT BENEFITS THAT CAN HELP LOW INCOME FAMILIES WITH CHILDREN!

HEALTH COVERAGE

MEDICAID BENEFITS FOR CHILDREN IN LOW INCOME WORKING FAMILIES

- ✔ Hospital care
- ✔ Medicine
- ✔ Immunizations
- ✔ Visits to the doctor
- ✔ Dental care
- ✔ Eyeglasses
- ✔ Preventive care

Medicaid eligibility for children is based on income, age of children and citizenship. Children through age 18 may get Medicaid. Eligibility levels are higher for children under age 6.

EXAMPLES:

In 1996, a mother with two children **under age 6** can have gross income of **$1,529** a month and get Medicaid coverage for both children.

If the two children are **age 6 through age 18**, she can have gross income of **$1,172** a month and still get Medicaid coverage for her children.

- **Children through age 18 may get Medicaid.**
- **Children do not have to be on welfare to get Medicaid.**
- **Children may get Medicaid even if both parents live in the home.**
- **One or both parents can work full time and the children may still get Medicaid.**
- **Children may get Medicaid even if their family has a car, a house and a savings account.**
- **A family with health insurance may still get Medicaid for their children.**

To obtain Medicaid coverage for children, an application must be filed providing information such as the family's income and social security numbers for the parent(s) and children. A family can apply at their local Department of Family and Children Services and, in most areas, they can apply at a regional hospital, a health department or a rural health clinic. (Call 1-800-869-1150 for more information.)

EARNED INCOME TAX CREDIT

Low income families (with children) who work part time or full time can get more take home pay through the Earned Income Tax Credit (EITC). The amount of extra money depends on income and family size. **A family does not have to owe any taxes to get the EITC.**

There are two ways a family can get the extra EITC money.

✔ **They can get all the extra EITC money when they file their federal tax return.**

OR

✔ **They can get part of the extra EITC money in advance with each paycheck and the rest when they file their tax return.**

To get the extra money in advance with each paycheck, the employee must file Form W-5 with their employer. Employees can get Form W-5 from their employer. (It does not cost the employer any money because it is taken out of the employee's federal withholding taxes.)

EXAMPLE: In 1996, a family (with two children) with gross income between **$741** and **$967** a month can get $3,556 in extra EITC money. The family can get the $3,556 when they file their federal tax return **OR** they can get $107 per month and the remaining $2,272 when they file their federal tax return.

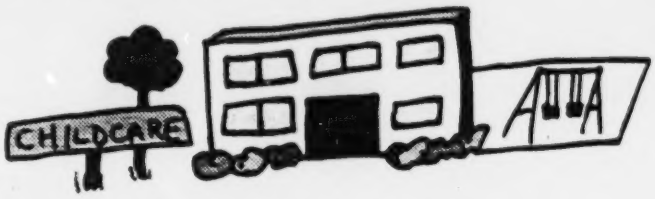
The EITC money is not counted as income when applying for Medicaid, AFDC, Food Stamps, Supplemental Security Income (SSI) or housing assistance.

To get the **EITC** a family **must** file a federal tax return. **FREE help is available to file tax returns.** Call the IRS at 1-800-829-1040 and ask where you can get help. (If it is busy, don't give up - keep calling because it is worth it to get free help with your tax return!)

Families can also apply for the **Georgia Low Income Credit.** For information, check your local telephone directory or call the information operator to get the number of the State Department of Revenue.

CHILD CARE

Assistance with child care may be available based on income. For example, in 1996, a family of three with gross income of **$1,417** a month may qualify for child care assistance.



Due to limited funding, the family may be placed on a waiting list. A family can get information on child care assistance at their local Department of Family and Children Services.

Families may choose where they place their child for child care. Choices may include child care centers and family child care in a home setting.

FOOD STAMPS

Low income families may qualify for Food Stamps while working full time. For example, in 1996, a family of three with gross income of **$1,250** a month may qualify to get $158 a month in Food Stamps.

CHILD SUPPORT

The local Child Support Office can help custodial parents obtain child support payments from absent parents. They can also assist in obtaining medical support and in establishing paternity.

- A parent does not have to be on welfare to get help in collecting child support or to receive other child support services.
- There are no guarantees that money will be collected, but getting help from Child Support Enforcement can improve the chances of success.
- Services do not include custody, visitation or other matters.
- There is a charge of only $1.00 for services provided by Child Support Enforcement, but there may be court filing fees and other court costs.

(For more information, call your local child support office.)

To learn more about benefits available for low income working families, call your local Department of Family and Children Services.

Design: Southern Institute on Children and Families/Shiben. Permission granted by the NC Department of Human Resources.

DHR

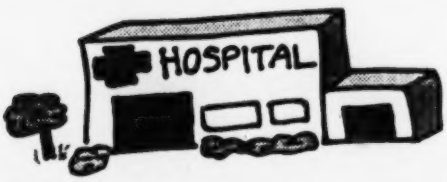
LEAVING WELFARE FOR WORK ISNT AS SCARY AS IT SEEMS

DID YOU KNOW YOU COULD WORK FULL TIME AND STILL RECEIVE SOME BENEFITS?

WHAT ARE THE BENEFITS FOR FAMILIES WHO LEAVE WELFARE FOR WORK?

- **Medicaid** (doctor visits, medicine, hospital care and checkups)
- **Child care assistance**
- **More take home pay**
- **Food Stamps**
- **Free help with filing tax return**

HEALTH COVERAGE



Families who get off of welfare because of work may still get family health coverage for parents and children for up to one year! It's called **Transitional Medicaid Assistance (TMA).**

After one year, depending on family income, the children are still likely to get health coverage through Medicaid–especially if they are under the age of six.

EXAMPLES:

In 1996, a mother with two children **under age 6** can have gross income of **$1,529** a month and get Medicaid coverage for both children.

If the two children are **age 6 through age 18**, she can have gross income of **$1,172** a month and still get Medicaid coverage for her children.

MEDICAID FOR CHILDREN IN LOW INCOME WORKING FAMILIES

- ✔ **Children through age 18 may get Medicaid.**
- ✔ **Children do not have to be on welfare to get Medicaid.**
- ✔ **Children may get Medicaid even if both parents live in the home.**
- ✔ **One or both parents can work full time and the children may still get Medicaid.**
- ✔ **Children may get Medicaid even if their family has a car, a house and a savings account.**
- ✔ **A family with health insurance may still get Medicaid for their children.**

EARNED INCOME TAX CREDIT

Low income families (with children) who work part time or full time can get **more take home pay** through the Earned Income Tax Credit **(EITC).** The amount of extra money depends on income and family size. A family does not have to owe any taxes to get the EITC.

There are two ways a family can get the extra EITC money.

✔ **They can get all the extra EITC money when they file their tax return.**

OR

✔ **They can get part of the extra EITC money in advance with each paycheck and the rest when they file their tax return.**

To get the extra money in advance with each paycheck, the employee must file Form W-5 with their employer. Employees can get Form W-5 from their employer or caseworker. (The advance does not cost the employer any money because it is taken out of the employee's federal withholding taxes.)

EXAMPLE: In 1996, a family (with two children) with gross income between **$741** and **$967** a month can get $3,556 in extra EITC money. The family can get the $3,556 when they file their federal tax return OR they can get $107 per month and the remaining $2,272 when they file their federal tax return.

To get the **EITC** a family **must** file a federal tax return. **FREE help is available to file tax returns.** Call the IRS at 1-800-829-1040 and ask where you can get help. (If it is busy, don't give up - keep calling because it is worth it to get free help with your tax return!)

There's more good news! The EITC money is not counted as income for Medicaid, AFDC, Food Stamps, SSI or housing assistance.

WHICH IS MORE?

WELFARE

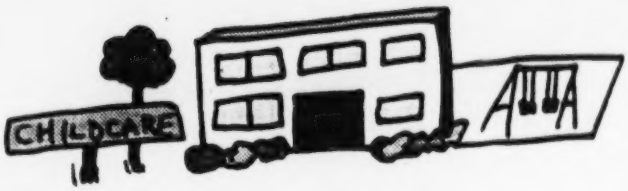
In 1996, a parent (with two children) on welfare without a job and no other income would get **$3,360** for the entire year.

EITC + PAYCHECK

If the same parent went to work earning **$11,600** a year (**$967** a month), the parent would get a paycheck **plus $3,556** in extra EITC money.

Families can also apply for the **Georgia Low Income Credit.** For information, check your local telephone directory or call the information operator to get the number of the State Department of Revenue.

CHILD CARE



Parents who get off welfare because of work may get some help with child care expenses for up to one year! The parent **must ask** for help with child care expenses. It's called **Transitional Child Care (TCC).**

After one year, the parent may still be able to get some help. The parent will still have to pay part of the fee, depending on income.

When receiving child care assistance, parents can choose where to take their children for child care.

FOOD STAMPS

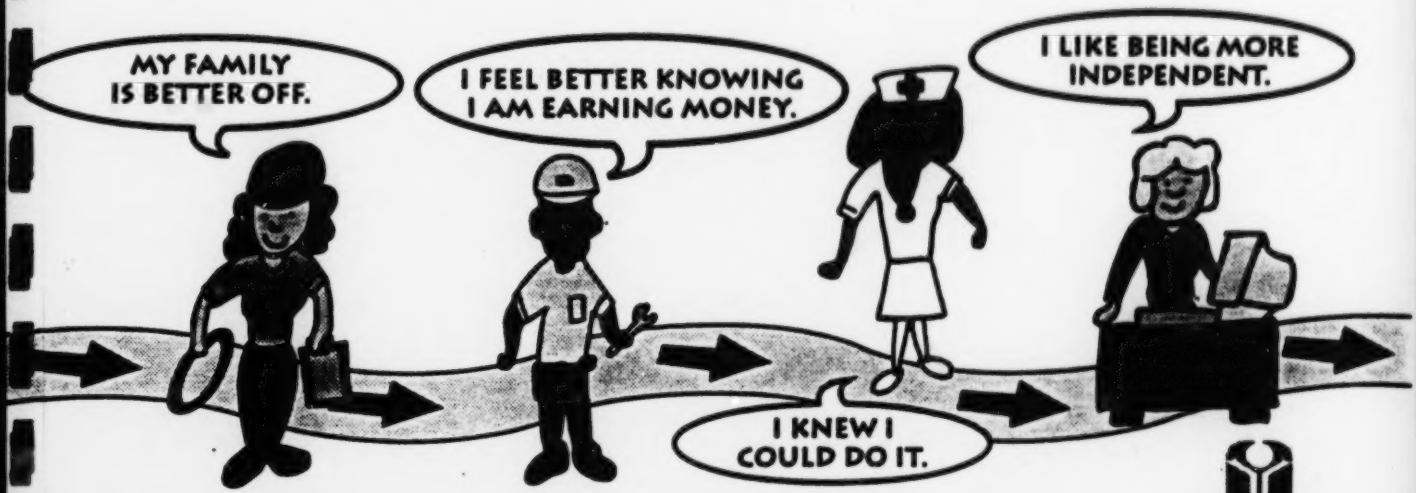
Parents who get off welfare because of work may still receive some assistance through the Food Stamp program.

EXAMPLE: In 1996, a family of three with gross income of **$1,250** a month may qualify to get $158 a month in Food Stamps.

SO, YOU SEE, FAMILIES DON'T LOSE ALL OF THEIR BENEFITS WHEN THEY LEAVE WELFARE FOR WORK. THEY MAY STILL GET:

•EITC cash •Child Care •Medicaid •Food Stamps

To learn more about leaving welfare for work (including getting child support), call your local Department of Family and Children Services.



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Facts For Employers

EMPLOYERS CONNECTING EMPLOYEES TO BENEFITS FOR LOW INCOME WORKING FAMILIES

Did you know you can help your low income workers make more money, get help with family health coverage and child care at no additional cost to you?

✔ **Check out these benefits that can help you hire and retain workers.**

Children do not have to be on welfare to be eligible for Medicaid coverage. Medicaid eligibility for children is based on family income, age of children and citizenship. Medicaid is available for children through age 18 in single and two parent families.

Parents who leave welfare for work may receive Medicaid for up to one year - children too! After one year, depending on the family's income, the children may still be eligible for Medicaid coverage.

Parents who leave welfare for work may receive help with child care expenses for at least one year. After one year, depending on the family's income and the availability of funding, the family may still qualify for assistance with child care expenses.

Low income working families can get more take home pay in their paycheck through the Earned Income Tax Credit (EITC). A portion of the EITC money can be received monthly and the remainder when they file their federal tax return—regardless of whether or not they owe taxes.

Low income families may qualify for Food Stamps while working full time. For example, a family of three with income at one and a half times the minimum wage may qualify for assistance through the Food Stamp program.

It's good business to be informed about benefits for low income working families.

Read on!

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GEORGIA MEDICAID PROGRAM FOR CHILDREN

Medicaid Benefits

- •Hospital Care
- •Visits to the doctor
- •Preventive Care
- •Medicine
- •Dental Care
- •Immunizations
- •Eyeglasses

✔ **Eligibility is based on income, age of children and citizenship**

✔ **No test for assets or resources**

✔ **Available for children in single and two parent families**

✔ **Available for children with health insurance**

To obtain Medicaid coverage for children, an application must be filed providing information such as the family's income and social security numbers for the parent(s) and children. A family can apply at their local Department of Family and Children Services and, in most areas, they can apply at a regional hospital, a health department or a rural health clinic. Call 1-800-869-1150.

EXAMPLE

In calculating Medicaid eligibility, certain deductions from income are allowed. For example, a two parent working family with children ages three and five and gross monthly income of $2,167 can take standard deductions for work ($90 each parent) and child care expenses (up to $175 for each child). These standard deductions reduce their monthly countable income to $1,637, making the children eligible for Medicaid.

MEDICAID ELIGIBILITY WORKSHEET	
Combined Gross Income (Both parents)	$2,167
Minus Standard Work Deduction ($90 for each parent)	-180
Minus Standard Child Care Deduction ($175 for each child)	-350
Countable Monthly Income	**$1,637**

The following table provides 1996 monthly Medicaid income guidelines by income and age of children. As illustrated on the worksheet above, families with gross incomes greater than the amount displayed below may still qualify for Medicaid due to standard deductions.

MONTHLY INCOME GUIDELINES MEDICAID ELIGIBILITY FOR CHILDREN (1996)			
Family Size (Parents and Children)	Infants up to age 1	Children Age 1 up to age 6	Children Age 6 through age 18
2	$1,597	$1,148	$863
3	$2,001	$1,439	$1,082
4	$2,405	$1,729	$1,300
NOTE: Income guidelines are adjusted upward annually to reflect increases in the poverty level.			

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EARNED INCOME TAX CREDIT

Low income working families (with children) can qualify to get more take home pay through the Earned Income Tax Credit (EITC). The amount of the EITC a family can receive depends on their income and the number of children in the household. In 1996, a family with two or more children can earn up to $28,495 a year and qualify for the EITC. A family does not have to owe taxes to receive the EITC.

There are two ways a family can get the EITC

✔ A family can get all the EITC when they file their federal tax return.

OR

✔ **A family can receive some portion of the EITC in advance with each paycheck and the rest when they file their tax return.** Employers should have employees complete Form W-5. (Call 1-800-829-3676 for free W-5 forms.) The employer adds a portion of the credit to the paycheck. The amount of the credit is then subtracted from the federal withholding deposit.

EXAMPLE

In 1996, a family with gross income between $8,890 and $11,610 per year (with two children) can qualify to receive the maximum EITC—$3,556. The family can elect to receive $3,556 in one refund payment when they file their federal tax return OR the family can elect to receive $107 a month in advance with their paycheck and the remaining $2,272 when they file their federal tax return.

To receive the EITC, a family must file a federal tax return. Free help is available in filing tax returns for families applying for the EITC. For information call the IRS at 1-800-829-1040. **Information can also be obtained from the Internet at http://www.irs.ustreas.gov.**

Promoting the EITC is smart business. It will increase the amount of a family's take home pay at no additional cost to the business.

Families can also apply for the **Georgia Low Income Credit.** For information, check your local telephone directory or call the information operator for the number of the State Department of Revenue.

CHILD CARE

Assistance with child care may be available based on income. Due to limited funding, the family may be placed on a waiting list.

Families may choose where they place their child for child care. Choices may include child care centers and family child care in a home setting.

A family can get information on child care assistance at the local Department of Family and Children Services.

MAKING THE TRANSITION FROM WELFARE TO WORK
Benefits for Families and Employers

✔ **Transitional Benefits.** Families who leave welfare for work are eligible for transitional benefits. Families on welfare for three of the preceding six months can receive the following assistance:

- Medicaid for parent and children for up to one year
- Child care assistance for up to one year

After one year, assistance may still be available depending on family income.

✔ **Employer Incentive.** There is a special on the job training program called Work Supplementation which provides incentives for public and private employers to hire welfare recipients. The jobs must represent newly created positions or positions that have been unfilled for 30 days. The jobs cannot be jobs that are unfilled due to a hiring freeze, layoff or strike. Here's how it works:

- The employer agrees to hire a welfare recipient, just as he would any other employee.
- The amount of government assistance check the recipient would have received is paid to the employer to offset the cost of training for up to nine months.

During the training period, the employee and the children, receive Medicaid coverage and child care. Once the training period is over, the employee and the children are eligible for the extended Medicaid and child care transitional benefits. The employer is expected to retain successful participants as regular employees.

It makes good *business* sense to help families move from welfare to work.

ACTIONS EMPLOYERS CAN TAKE TO HELP LOW INCOME FAMILIES

- Obtain brochures on Medicaid, the EITC, Food Stamps and available child care assistance.
- Post information on Medicaid, the EITC, Food Stamps and available child care assistance in employee break rooms, rest rooms and on bulletin boards.
- Provide verification of an employee's wages and income promptly when requested. (Encourage your employees to retain check stubs for purpose of verification.)
- Have W-5 forms on hand for employees who wish to receive advance payment of the EITC.
- Have representatives from Medicaid, child care, Food Stamps and the EITC visit your company to present information on their programs.
- Have representatives from Medicaid visit your company to take applications for Medicaid.

If you or an employee would like more information on Medicaid, the Earned Income Tax Credit, Food Stamps, child care assistance or Work Supplementation, call your local Department of Family and Children Services.

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DHR
GEORGIA
DEPARTMENT OF HUMAN RESOURCES

APPENDIX D

SOUTH CAROLINA
PARTNERS FOR HEALTHY CHILDREN APPLICATION

South Carolina
Partners for Healthy Children

Dear Parent,

Welcome to **Partners for Healthy Children**, our new program of health coverage for children. **Partners for Healthy Children** provides free health care to children in families with low income. Health care can be expensive. I am pleased that South Carolina can offer this help to your family as you struggle to meet your child's needs.

So I want to join in a partnership with you. We will provide **Partners for Healthy Children** and, if your family qualifies, your child's health care will be free. But you need to join us as a partner, too. You are in charge of the health care your child receives. You need to fill out and mail an application for **Partners for Healthy Children**. After you get your **Partners for Healthy Children** card in the mail, you will need to make appointments with a doctor and make sure your child gets the health care he needs.

Look at the chart on the back of this letter. If your family income is no more than the amount shown for your family size, your children should qualify for **Partners for Healthy Children.** To apply, simply fill out the attached application form and mail it in.

If your income is greater than the amount on the chart, *your children may still qualify*. In that case, go to one of the locations listed on the back of this letter and ask for assistance in applying for **Partners for Healthy Children**.

I hope this will be a great year for your family and I hope **Partners for Healthy Children** will help you provide the health care for your children that you decide they need.

Sincerely,

David M. Beasley

Office of the Governor
Post Office Box 11369
Columbia, South Carolina 29211

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Application
South Carolina
Partners for Healthy Children

If you have Medicaid, you do not need to fill out this form.

1. Tell us who you are and where you live.

Last name (Parent's)	First Name (Parent's)	Middle Initial	Phone	
Street Address	City	State	Zip Code	County
Mailing Address, if different	City	State	Zip Code	

2. Tell us who in your family lives with you. List the parent shown in item 1, on the first line below.

[redacted] List parent(s) and children	First Name List parent(s) and children	Middle Initial	Sex	Race	Date of Birth	Social Security Number	How is this person related to you?

3. Tell us how much income your family has.

Fill in the amount of money you make. If you are married and your spouse works, fill in the amount of money your spouse makes, too. Check one box to show if the amount is hourly, weekly, monthly or yearly. **Enter GROSS pay, not take home pay.** Enter zero ("0") if you or your spouse have no earned income.

[redacted] Your Income	Spouse's Income
Amount you earn: $_____	Amount your spouse earns: $_____
☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly	☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly
Hours worked each week _____	Hours worked each week _____
Employer Name and Phone Number	Employer Name and Phone Number

4. Tell us if you have any other income.

List any additional income you or family members living with you may have from the sources listed below and tell us how often you get this income (for example, once each week, every three months, once a year, etc.)

[redacted] Source	[redacted]	How Often	Who Gets this Money?
Interest from bank account	$		
Child support	$		
Alimony	$		
Social Security payment	$		
Other (Please explain)	$		

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5. Attach proof of income.

We need proof of your income. For earnings, provide copies of pay stubs for the last four weeks. If you do not have pay stubs, you may provide a letter from your employer or a copy of your most recent state or federal income tax form. Other documents can be used to provide proof of income. If you are not sure what to send, call our toll-free number 1-888-549-0820 and we will help you.

6. Tell us about any health insurance you already have.

Tell us the name of your insurance company, the policy number and the insured persons name on the policy. Even if you already have health insurance, you can still qualify for **Partners for Healthy Children.**

[illegible] Company or Employer	Company or Employer	[illegible] Number	Insured (name on policy) [illegible]

7. Tell us whether any child received medical services in the last three months.

Did any of your children living with you receive medical services in the past 3 months:

☐ Yes ☐ No

8. Please sign this statement.

I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of South Carolina to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information. I certify that the children listed on this application are U.S. citizens or lawful immigrants.

Signature of applicant:_____ Date _____

9. Mail this completed, signed form, together with proof of income, to:

South Carolina Partners for Healthy Children
Post Office Box 100101
Columbia, South Carolina 29202-3101

If you need more information, please call this toll-free number: 1-888-549-0820.

Rights and Responsibilities

Partners for Healthy Children is a program funded through a partnership with regional hospitals, state government and the federal government.

1. I know that my children under age 19 who are eligible for Partners for Healthy Children can have free health checkups under a special Partners for Healthy Children prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs.

2. I know that the information I have given is confidential. I agree that medical information about my children can be released only if needed to administer this program.

3. I know that any information I have given may be reviewed and verified by State of South Carolina staff. Also I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission is needed to get verification or other information.

4. I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.

5. I know that I may ask for a hearing if I am not satisfied with any action taken by the State of South Carolina in connection with the Partners for Healthy Children program. I may also ask for a hearing if I feel that I have been discriminated against.

6. I know that the State of South Carolina will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares the Partners for Healthy Children information about me and other members of my family with information from other agencies. Other agencies may include the Internal Revenue Service, Social Security Administration and Employment Security Commission.

7. I know that Partners for Healthy Children does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. If my children get Partners for Healthy Children, I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I know that if I refuse to give my rights to third party payments to the Department of Health and Human Services, my children will not be eligible to receive a Partners for Healthy Children card.

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Do Your Children Qualify for Free Health Care from Partners for Healthy Children?

Number of people in family (Count parent(s) and children)	Income levels to qualify for Partners for Healthy Children (Income slightly above may still qualify. See NOTE below.)			
	Hourly wage	Weekly income	Monthly income	Annual income
2	$7.65	$306	$1,327	$15,915
3	$9.63	$385	$1,667	$19,995
4	$11.58	$463	$2,007	$24,075
5	$13.53	$541	$2,347	$28,155
6	$15.50	$620	$2,687	$32,235
7	$17.45	$698	$3,027	$36,315
8	$19.43	$777	$3,367	$40,395

The number of people in the family includes the parents and the children. Add together all the income received by all family members and see if your income is not more than the amounts above. If so, your children should qualify. If more than 8 people live in your family, please call 1-888-549-0820 for assistance.

NOTE: If your family income is slightly more than the amounts on the chart above, you may still qualify but you will need to apply in person, at one of the following offices. Call the phone number in your county to find out where and when to go to apply. Many county DSS offices have Medicaid eligibility workers located at hospitals, health departments, or federally qualified health centers where applications can be filed also.

Abbeville County DSS
459-5481

Aiken County DSS
642-3650

Allendale County DSS
584-7063

Anderson County DSS
260-4100

Bamberg County DSS
245-4363

Barnwell County DSS
541-1210

Beaufort County DSS
525-7861

Berkeley County DSS
761-8044

Calhoun County DSS
874-3384

Charleston County DSS
792-0444

Cherokee County DSS
487-2704

Chester County DSS
377-8131

Chesterfield County DSS
623-2150

Clarendon County DSS
435-4305

Colleton County DSS
549-6090

Darlington County DSS
398-4420

Dillon County DSS
774-8284

Dorchester County DSS
563-4337

Edgefield County DSS
637-4040

Fairfield County DSS
635-5502

Florence County DSS
669-3354

Georgetown County DSS
546-5134

Greenville County DSS
467-7700

Greenwood County DSS
229-5258

Hampton County DSS
943-3841

Horry County DSS
365-5565

Jasper County DSS
726-7747

Kershaw County DSS
432-7676

Lancaster County DSS
286-6914

Laurens County DSS
833-0100

Lee County DSS
484-5376

Lexington County DSS
957-7333

McCormick County DSS
465-2627

Marion County DSS
423-4823

Marlboro County DSS
479-4520

Newberry County DSS
321-2155

Oconee County DSS
638-4400

Orangeburg County DSS
531-3101

Pickens County DSS
898-5810

Richland County DSS
735-7048

Saluda County DSS
445-2139

Spartanburg County DSS
596-3099

Sumter County DSS
773-5531

Union County DSS
429-1660

Williamsburg County DSS
354-5411

York County DSS
684-8108

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APPENDIX E

STATE BY STATE DATA ON AFDC APPLICATION DENIALS

STATE BY STATE DATA ON APPLICATION DENIALS

Area	% Of Applications Denied	No. Of Cases Denied	No. Of Individuals Denied	Percentage of Cases Denied By Reason			
				Excess Income	Excess Resources	Failure To Comply	Other
UNITED STATES	31.4%	818,809	2,309,041	23.3%	4.8%	55.2%	17.5%
ALABAMA	35.4%	14,470	40,805	25.5%	1.8%	67.7%	4.9%
ALASKA	32.2%	5,191	14,639	26.2%	12.3%	36.6%	24.8%
ARIZONA	49.2%	46,141	130,118	25.0%	1.6%	54.9%	18.4%
ARKANSAS	37.5%	16,954	47,810	18.2%	2.6%	72.1%	7.1%
CALIFORNIA	28.1%	153,116	431,787	15.6%	7.9%	51.0%	25.6%
COLORADO	27.2%	21,433	60,441	11.7%	5.7%	78.3%	4.3%
CONNECTICUT	18.5%	5,077	14,317	30.2%	3.1%	51.2%	15.5%
DC	28.6%	2,608	7,355	22.0%	5.9%	46.3%	25.8%
DELAWARE	30.3%	3,592	10,129	24.4%	7.0%	27.3%	41.3%
FLORIDA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
GEORGIA	37.3%	45,284	127,701	18.6%	1.2%	59.7%	20.4%
GUAM	29.3%	511	1,441	5.7%	4.1%	67.0%	23.2%
HAWAII	29.7%	4,742	13,372	36.6%	24.8%	19.8%	18.8%
IDAHO	43.6%	N/A	N/A	23.6%	6.1%	57.3%	12.9%
ILLINOIS	23.0%	37,916	106,923	15.0%	0.0%	79.7%	5.2%
INDIANA	37.6%	39,559	111,556	66.1%	7.8%	19.8%	6.3%
IOWA	24.2%	15,522	43,772	33.7%	2.1%	51.1%	13.1%
KANSAS	22.7%	N/A	N/A	51.1%	5.8%	38.3%	4.8%
KENTUCKY	33.5%	25,548	72,045	4.7%	0.5%	47.0%	47.7%
LOUISIANA	30.7%	26,689	75,263	23.2%	6.4%	61.6%	8.7%
MAINE	29.2%	N/A	N/A	35.9%	5.5%	38.0%	20.6%
MARYLAND	29.5%	N/A	N/A	25.6%	2.7%	59.4%	12.4%
MASSACHUSETTS	23.1%	10,480	29,554	7.7%	3.1%	79.0%	10.2%
MICHIGAN	33.4%	N/A	N/A	39.7%	3.4%	53.5%	3.3%
MINNESOTA	9.4%	N/A	N/A	31.0%	11.7%	49.3%	8.1%
MISSOURI	24.6%	15,828	44,635	51.9%	4.8%	30.1%	13.1%
MISSISSIPPI	30.3%	12,936	36,480	48.5%	4.6%	33.2%	13.8%
MONTANA	32.3%	5,260	14,890	31.5%	7.9%	35.6%	24.9%
NORTH CAROLINA	15.1%	N/A	N/A	39.2%	6.5%	5.5%	48.8%
NORTH DAKOTA	24.6%	1,771	4,994	37.9%	10.6%	19.8%	31.7%
NEBRASKA	20.4%	1,988	5,606	31.0%	5.5%	42.4%	21.1%
NEVADA	48.0%	22,278	62,824	11.2%	1.0%	82.5%	5.2%
NEW HAMPSHIRE	42.6%	5,407	15,248	31.0%	5.6%	25.1%	38.3%
NEW JERSEY	10.2%	8,181	23,070	13.3%	5.8%	71.2%	9.8%
NEW MEXICO	39.1%	16,732	47,184	21.7%	8.9%	47.2%	22.2%
NEW YORK	9.7%	N/A	N/A	21.0%	4.0%	72.2%	2.9%
OHIO	44.3%	N/A	N/A	69.0%	5.4%	13.7%	11.9%
OKLAHOMA	35.0%	16,790	47,348	26.4%	2.5%	59.9%	11.3%
OREGON	16.3%	3,481	9,816	18.6%	5.5%	68.3%	7.6%
PENNSYLVANIA	11.0%	N/A	N/A	26.9%	6.7%	63.7%	2.7%
PUERTO RICO	26.5%	5,704	16,085	0.0%	16.0%	77.6%	6.4%
RHODE ISLAND	24.2%	4,562	12,865	26.9%	6.9%	52.1%	14.1%
SOUTH CAROLINA	30.9%	18,628	52,531	21.7%	4.1%	65.2%	9.0%
SOUTH DAKOTA	8.9%	1,148	3,237	45.8%	6.4%	28.7%	19.1%
TENNESSEE	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TEXAS	38.3%	131,898	371,952	11.7%	3.6%	69.7%	14.9%
UTAH	31.0%	7,646	21,562	35.5%	4.1%	42.6%	17.7%
VIRGINIA	29.4%	18,342	51,724	24.6%	5.3%	60.7%	9.5%
VIRGIN ISLANDS	9.2%	33	93	18.2%	3.0%	24.2%	54.5%
VERMONT	30.7%	4,850	13,677	44.9%	5.6%	23.8%	25.7%
WASHINGTON	41.1%	N/A	N/A	47.0%	10.7%	34.6%	7.7%
WEST VIRGINIA	18.2%	5,591	15,767	32.1%	7.9%	51.1%	8.9%
WISCONSIN	54.3%	33,448	94,323	57.9%	4.4%	3.3%	34.3%
WYOMING	17.6%	1,454	4,100	32.3%	8.9%	52.3%	6.5%

Notes: 1) Data for Florida and Tennessee were not reported by the US Department of Health and Human Services. Three quarters of data were reported for Idaho, Kansas, Maryland, Michigan, Minnesota, North Carolina, New York, Ohio and Pennsylvania. Two quarters of data were reported for Maine and Washington. 2) The US figure only includes the states that reported four quarters of data in FFY 1996. 3) The number of individuals was estimated based on an average number of persons per case of 2.82. 4) "Other" reasons for denial are "no eligible child," "child not deprived of support or care," "alien," "nonresident, "and "unknown."

Source: Calculations by the Southern Institute on Children and Families of data from the US Department of Health and Human Services.

APPENDIX F

STATE CONTACTS FOR INFORMATION ON HEAD START COLLABORATION

State Contacts for Head Start

State	Contact	Telephone #
Arkansas	Tonya Russell	501/371-0740
Delaware	Betty Richardson	302/739-4667
Georgia	Barbara Watson	404/651-8264
Kentucky	Kurt Walker	502/564-3010
	Lydia Roberts	502/564-2454
Maryland	Sandy Fallin	410/728-8844
Mississippi	Ronnie F. McGinnis	601/359-4555
Missouri	Patti Martin	573-884-0579
North Carolina	Ron Moore	919/662-4543
Oklahoma	Eva Carter	405/524-4124
South Carolina	Kitty Casoli	803/253-6154
Tennessee	Wanda Moore	615/313-4866
	Louis Rudolph	615/313-4866
Texas	Sherry Ravan	512/936-3215
Virginia	Francine Bryce	804/692-0935
West Virginia	Bill Huebner	304/558-0600

Southern Institute on Children and Families

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